

Tuesday
September 1, 1992

Federal Register

Briefing on How To Use the Federal Register
For information on a briefing in Atlanta, GA, see
announcement on the inside cover of this issue.

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THE FEDERAL REGISTER

WHAT IT IS AND HOW TO USE IT

- FOR:** Any person who uses the Federal Register and Code of Federal Regulations.
- WHO:** The Office of the Federal Register.
- WHAT:** Free public briefings (approximately 3 hours) to present:
1. The regulatory process, with a focus on the Federal Register system and the public's role in the development of regulations.
 2. The relationship between the Federal Register and Code of Federal Regulations.
 3. The important elements of typical Federal Register documents.
 4. An introduction to the finding aids of the FR/CFR system.
- WHY:** To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

ATLANTA, GA

- WHEN:** September 17, at 9:00 a.m.
- WHERE:** Centers for Disease Control
1600 Clinton Rd., NE.
Auditorium A
Atlanta, GA (Parking available)
- RESERVATIONS:** [404-639-3528 (Atlanta area)]
1-800-347-1997 (outside Atlanta area)

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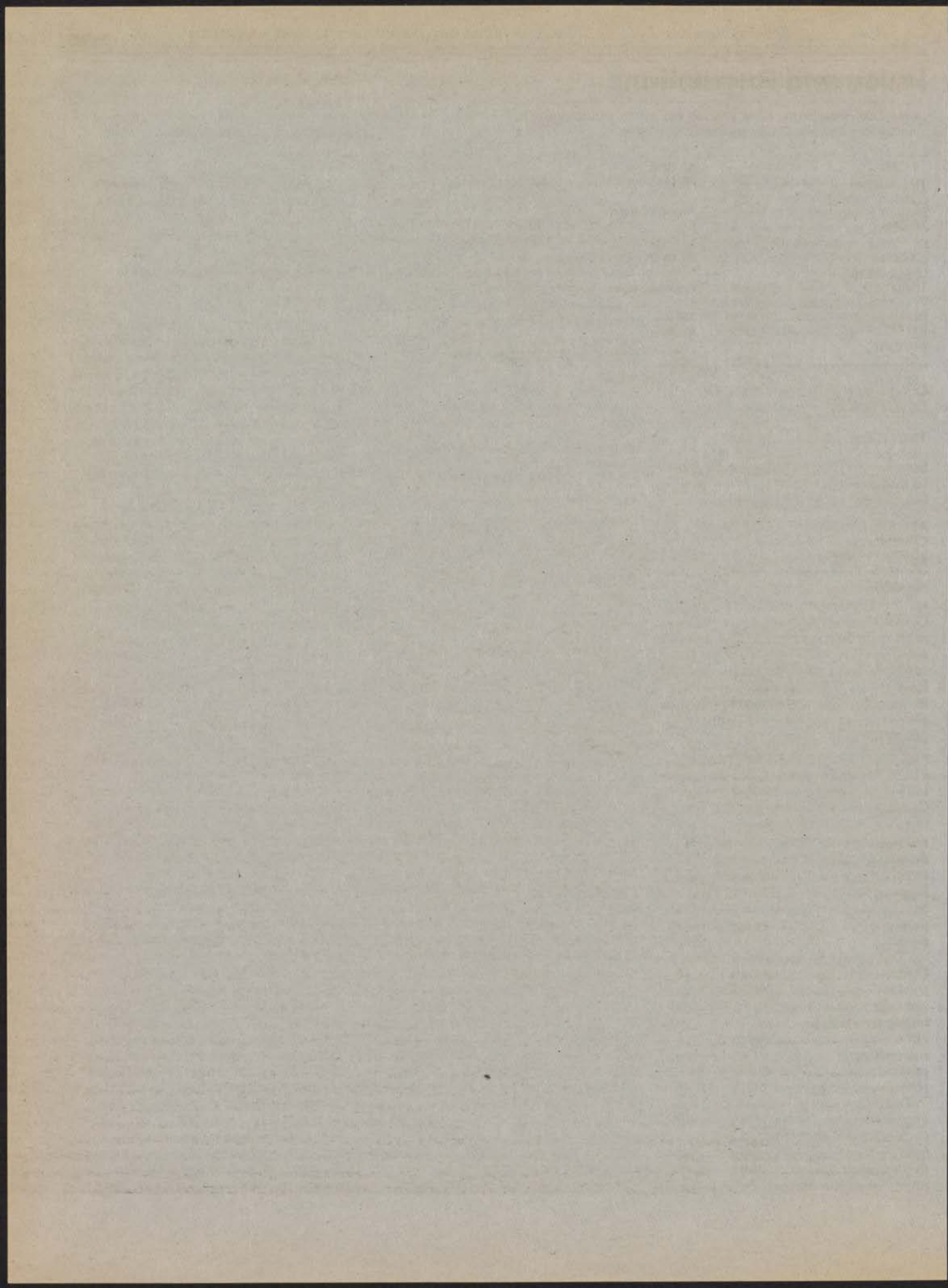
Reader Aids

Additional information, including a list of public laws, telephone numbers, and finding aids, appears in the Reader Aids section at the end of this issue.

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Rules and Regulations

Federal Register

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This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510. The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

CONSUMER PRODUCT SAFETY COMMISSION

16 CFR Part 1115

Substantial Hazard Reports; Revision to Interpretative Rule Governing Substantial Hazard Reporting

AGENCY: Consumer Product Safety Commission.

ACTION: Correction of rule.

SUMMARY: Because of changes in its statute, the Consumer Product Safety Commission revised its interpretative rules regarding the reporting of possible substantial product hazards. These revisions were published in the Federal Register on August 4, 1992. This notice is to correct a sentence in that publication. **EFFECTIVE DATE:** The revisions become effective September 3, 1992.

FOR FURTHER INFORMATION CONTACT: Eric L. Stone, Division of Administrative Litigation, Consumer Product Safety Commission, Washington, DC 20207; telephone (301) 504-0626.

SUPPLEMENTARY INFORMATION: This document corrects a sentence in the amendments published in the Federal Register on August 4, 1992. (57 FR 34222). The fourth sentence of the first paragraph in § 1115.5(a) on page 34228 reads:

"This provision applies only when the Commission relies upon a voluntary standard in a rulemaking proceeding under section 9 of the CPSA, and does not apply when the Commission relies upon a voluntary standard in a rulemaking proceeding under another provision of the CPSA or one of the transferred acts."

This correction is being made to ensure that there is no inference that the Commission decision to publish the interpretative rule endorsed the notion that reliance can occur under another provision of the CPSA.

The Commission corrects on page 34228 the fourth sentence of section 1115.5(a) to read:

§ 1115.5 Reporting of failures to comply with a voluntary consumer product safety standard relied upon by the Commission under section 9 of the CPSA.

(a) * * * This provision applies only when the Commission relies upon a voluntary standard in a rulemaking proceeding under section 9 of the CPSA.

* * *

Dated: August 27, 1992.

Sheldon Butts,

Acting Secretary, Consumer Product Safety Commission.

[FR Doc. 92-21010 Filed 8-31-92; 8:45 am]

BILLING CODE 6355-01-M

DEPARTMENT OF THE TREASURY

Bureau of Alcohol, Tobacco and Firearms

27 CFR Part 194

[T. D. ATF-329; CRT-92-73]

Registration of Catering Locations

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Department of the Treasury.

ACTION: Treasury decision, final rule.

SUMMARY: ATF is amending regulations in 27 CFR part 194 to eliminate certain registration requirements imposed on caterers who change the location at which they sell or offer for sale alcoholic beverages, except when there is a permanent change of location of the principal place of business. Under current requirements, caterers must complete and submit two forms reflecting such changes: ATF Form 5630.5 (Special Tax Registration and Return) and ATF Form 5100.29 (Catering Locations). The amended regulations will eliminate this requirement. The final rule will require caterers to maintain adequate commercial records to support that all locations where alcoholic beverages were sold or offered for sale were covered by a special (occupational) tax payment. The final rule will require that these records must be kept available for ATF inspection in order to verify proper tax payments.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT:

Shirley C. Osborne, Tax Compliance Branch (202-927-8220), 650 Massachusetts Avenue, NW., Washington, DC 20226.

SUPPLEMENTARY INFORMATION:

Background

Retailers (including caterers) of alcoholic beverages (liquor, wine, and/or beer) must pay special (occupational) tax at an annual rate of \$250 per year, as required by 26 U.S.C. 5121. Under 26 U.S.C. 5143(c), a separate tax is imposed on each location at which alcoholic beverages are sold or offered for sale. The Bureau of Alcohol, Tobacco and Firearms (ATF) issues a tax stamp for each location for which special (occupational) tax is paid. If a retail dealer conducts business at more than one location, the taxpayer must pay special (occupational) tax and obtain a tax stamp for each location. Under 26 U.S.C. 5143(d), a special (occupational) taxpayer is allowed to change the location of the business without incurring additional tax by registering the change. This registration must be done within 30 days of the date the taxpayer begins to sell (or offer for sale) alcoholic beverages at the new location. Failure to register the change of location within 30 days make the dealer liable for an additional tax payment to cover the new location.

Caterers who sell (or offer for sale) alcoholic beverages at locations other than their principal business locations must acquire a sufficient number of tax stamps to ensure that they have as many separate tax stamps as the maximum number of locations at which they will be selling (or offering for sale) alcoholic beverages at any one time. Where a caterer dispenses (but does not sell or offer for sale) alcoholic beverages at one or several locations other than the caterer's office under contracts made at the caterer's office, no additional tax stamps are required.

Caterers who sell (or offer for sale) alcoholic beverages at locations other than the place of business for which a special tax stamp is held are currently required to register such locations within 30 days of the date of the first such sale, using ATF Form 5100.29, Catering Locations. ATF Form 5100.29 is filed with ATF in duplicate by the caterer, showing the name and address

of each place at which alcoholic beverages are sold or offered for sale and the dates and times during which such catering occurred, along with an amended ATF Form 5630.5, Special Tax Registration and Return, clearly marked "Caterer-Amended Return." ATF Form 5100.29 identifies where alcoholic beverages were sold by the drink at locations other than the location listed on the special occupational tax stamp issued to the caterer. ATF endorses both copies of ATF Form 5100.29 and returns a copy to the taxpayer to attach to his or her tax stamp.

This Treasury decision eliminates the current regulatory filing requirements for caterers set forth in 27 CFR 194.151(b). This decision will require caterers to maintain adequate commercial records pursuant to 27 CFR 194.55(c) enabling ATF to verify that all required special (occupational) tax has been paid for all locations subject to this tax. These records must establish that the caterer has a sufficient number of special (occupational) tax stamps to cover the number of locations at which it may conduct business at any one time. Pursuant to 27 CFR 194.151(a), caterers will continue to be required to file an amended return, ATF Form 5630.5, for changes in the address of the permanent place of business.

Regulatory Flexibility Act

The provisions of the Regulatory Flexibility Act relating to an initial and final regulatory flexibility analysis are not applicable to this final rule because the agency was not required to publish a general notice of proposed rulemaking under 5 U.S.C. 553 or any other law. A copy of this final rule has been submitted to the Administrator of the Small Business Administration for comment on the impact of such regulation on small business, pursuant to 26 U.S.C. 7805(f).

Executive Order 12291

It has been determined that this document is not a major regulation as defined in Executive Order 12291 and a regulatory impact analysis is not required because it will not have an annual effect on the economy of \$100 million or more; it will not result in a major increase in costs or prices for consumers, individual industries, Federal, state, or local government agencies, or geographic regions, and it will not have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or foreign markets.

Administrative Procedure Act

Because this Treasury decision merely eliminates certain registration requirements for location changes for caterers that sell or offer to sell alcoholic beverages, it is found to be unnecessary to issue this Treasury decision with notice and public procedure thereon under 5 U.S.C. 553(b) or subject to the effective date limitation in 5 U.S.C. 553(d).

Paperwork Reduction Act

The collection of information described in this final rule has been submitted to the Office of Management and Budget (OMB) for review and comment in accordance with the Paperwork Reduction Act of 1980 (44 U.S.C. 3504(h)).

The estimated average burden associated with the Catering Location Registration was .5 hours per respondent. We estimate that eliminating this form will save 250 burden hours per year.

Drafting Information

The principal author of this document is Shirley C. Osborne of the Tax Compliance Branch, Bureau of Alcohol, Tobacco and Firearms.

List of Subjects in 27 CFR Part 194

Alcohol and alcoholic beverages, Authority delegations (Government agencies), Beer, Claims, Excise taxes, Exports, Labeling, Liquors, Packaging and containers, Penalties, Report and recordkeeping requirements, Wine.

Authority and Issuance

27 CFR part 194, Liquor Dealers, is amended as follows:

PART 194—LIQUOR DEALERS

Paragraph 1. The authority citation for part 194 continues to read as follows:

Authority: 26 U.S.C. 5001, 5002, 5111–5117, 5121–5124, 5142, 5143, 5145, 5146, 5206, 5207, 5301, 5352, 5555, 5613, 5681, 5691, 6001, 6011, 6061, 6065, 6071, 6091, 6109, 6151, 6311, 6314, 6402, 6511, 6601, 6621, 6651, 6657, 7011, 7805.

Par. 2. Section 194.55 is amended by adding a new paragraph (c) and revising the authority citation to read as follows:

§ 194.55 Caterers.

(c) *Records.* Caterers must maintain sufficient commercial records to verify that their special (occupational) tax liabilities have been satisfied for all locations at which activities subject to special (occupational) tax occur. These commercial records should indicate the names and addresses of locations at which alcoholic beverages have been

sold or offered for sale and the dates and times that such activities occurred. These commercial records must be available to ATF officers upon request. (26 U.S.C. 5121, 5122, 5143, 5555, 6806, 7011)

Par. 3. Section 194.151(b) is revised to read as follows:

§ 194.151 Amended return, Form 5630.5; endorsement on stamp.

(b) *Caterers.* A caterer who sells liquor by the drink at locations other than his or her principal place of business shall not be required to provide the change of location registration prescribed in paragraph (a) of this section for such catering activities provided the records prescribed by § 194.55(c) are maintained as required. For a permanent change in location of the principal place of business, an amended return must be filed in accordance with paragraph (a) of this section.

Signed: June 2, 1992.

Stephen E. Higgins,

Director.

Approved: August 19, 1992.

John P. Simpson,

Acting Assistant Secretary (Enforcement).

[FR Doc. 92-20966 Filed 8-31-92; 8:45 am]

BILLING CODE 4810-31-M

DEPARTMENT OF JUSTICE

28 CFR Parts 50 and 80

[AG Order No. 1620-92]

Antibribery Provisions of the Foreign Corrupt Practices Act

AGENCY: Department of Justice.

ACTION: Final rule.

SUMMARY: The Department of Justice is today publishing a final rule establishing a Foreign Corrupt Practices Act Opinion Procedure. This procedure will enable issuers and domestic concerns to obtain an opinion of the Attorney General regarding whether prospective conduct would conform with the Department of Justice's present enforcement policy regarding the antibribery provisions of the Foreign Corrupt Practices Act. This procedure implements amendments made to the antibribery provisions of the Foreign Corrupt Practices Act by Title V of the Omnibus Trade and Competitiveness Act of 1988. This final rule adopts the FCPA Opinion Procedure in the same form as published for comment on January 9, 1992, without change.

EFFECTIVE DATE: October 1, 1992.

FOR FURTHER INFORMATION CONTACT:

Peter B. Clark, Deputy Chief, Fraud Section, Criminal Division, U.S. Department of Justice, room 2424, Bond Building, 1400 New York Avenue, NW., Washington, DC, (202) 514-0651.

SUPPLEMENTARY INFORMATION: The antibribery provisions of the Foreign Corrupt Practices Act of 1977, as amended (FCPA or the Act), 15 U.S.C. 78dd-1 and 78dd-2, are aimed at eliminating bribery of foreign government officials by issuers and domestic concerns. In 1988, the antibribery provisions of the FCPA were amended by section 5003 of the Omnibus Trade and Competitiveness Act of 1988, Public Law 100-418. As amended, the antibribery provisions require the Attorney General to establish a procedure to respond to inquiries concerning whether prospective conduct would conform with the Department of Justice's present enforcement policy. 15 U.S.C. 78dd-1(e) and 78dd-2(f).

On January 9, 1992, the Department of Justice published for comment proposed regulations establishing a Foreign Corrupt Practices Act Opinion Procedure. 57 FR 862. One comment was received. It was favorable to the proposal as published. The commentor also suggested that the Department of Justice consider establishing an opinion record to apply past opinions as precedent. The suggestion would be inconsistent with the function for which opinions are provided, to furnish an indication of the Department's current enforcement policy on a specific factual situation, and therefore is not adopted.

As set forth below, the FCPA Opinion Procedure is based upon the existing FCPA Review Procedure, 28 CFR 50.18, established by the Department of Justice in 1980. The FCPA Review Procedure will be revoked when the proposed FCPA Opinion Procedure becomes effective.

Under the FCPA Opinion Procedure, issuers and domestic concerns within the meaning of 15 U.S.C. 78dd-1 and 78dd-2, respectively, may submit a proposed transaction to the Attorney General for review. The Attorney General will then issue an opinion stating whether or not certain specified prospective conduct would, for purposes of the Department of Justice's present enforcement policy, violate the Act's antibribery provisions and lead the Department of Justice to take enforcement action. The FCPA Opinion Procedure will not be available for matters relating to the recordkeeping

provisions of the FCPA. 15 U.S.C. 78m(b) (2) and (3).

As amended, Sections 78dd-1(e) and 78dd-2(f) provide that the Attorney General's opinion that disclosed conduct conforms with the Department of Justice's present enforcement policy creates a rebuttable presumption of compliance with the antibribery provisions of the FCPA. This presumption may be rebutted by a preponderance of the evidence. These provisions are incorporated in § 80.10 of the proposed FCPA Opinion Procedure.

As is the case with the existing FCPA Review Procedure, the Attorney General's opinion will be binding on the Department of Justice only as to the issuer or domestic concern submitting the request and no agency other than the Department of Justice will be bound. The Department of Justice has responsibility for all criminal enforcement of the antibribery provisions of the FCPA, and also for civil enforcement of 15 U.S.C. 78dd-2, which applies to domestic concerns. The Securities and Exchange Commission (SEC) has responsibility for civil enforcement of 15 U.S.C. 78dd-1, which applies to issuers. Notwithstanding the issuance of an FCPA opinion by the Attorney General, the SEC remains free to take a civil enforcement action against any domestic concern. Nevertheless, by statute the rebuttable presumption arising from an FCPA Opinion applies "[i]n any action brought" under the applicable provisions of the Act, 15 U.S.C. 78dd-1(e)(1) and 78dd-2(f)(1) (emphasis supplied). Collateral consequences of a violation of the antibribery provisions of the Act may include government-wide suspension or debarment from participation in Federal programs under guidelines issued by the Office of Management and Budget (53 FR 19161, May 26, 1988).

The FCPA Opinion Procedure differs from the existing FCPA Review Procedure in several respects to reflect the amendments made to 15 U.S.C. 78dd-1 and 78dd-2 in 1988. Among the differences, the procedure eliminates the Department of Justice's discretion, under the existing FCPA Review Procedure, to refuse to review a request. Further, the procedure requires the Attorney General to issue an opinion within 30 days after a request is deemed complete. In contrast, the existing FCPA Review Procedure states that "every reasonable effort" will be made to respond to requests within 30 days after receipt of the request or any additional information sought by the Department. Both the existing procedure and the new FCPA Opinion Procedure permit the

Department of Justice to request additional information. The FCPA Opinion Procedure states that a request is not deemed to be complete until the issuer or domestic concern submitting the request provides the Department all additional information that it seeks, and requires the Department to request additional information, where needed, within 30 days.

The FCPA Opinion Procedure also contains an exemption from disclosure under the Freedom of Information Act, 5 U.S.C. 552, of any document or other material which is provided to, received by, or prepared in connection with a request. This exemption incorporates the statutory exemption from disclosure set forth in 15 U.S.C. 78dd-1(e)(2) and 78dd-2(f)(2).

Finally, the FCPA Opinion Procedure provides that a request may only be withdrawn before the Attorney General issues an opinion, and that a withdrawn request shall have no force or effect. This accommodates the statutory requirements of 15 U.S.C. 78dd-1(e)(3) and 78dd-2(f)(3). The existing FCPA Review Procedure allows a request to be withdrawn at any time, and permits the Department to submit to the requesting party any comments on the withdrawn request that it deems appropriate.

After considering the comments received, and consulting with the Departments of State, Treasury and Commerce, and with the Office of the United States Trade Representative and the SEC, the proposed rule has been adopted as a final regulation, without change.

The Department, in cooperation with the Department of Commerce, intends to produce for public distribution a brochure explaining, generally, the provisions of the FCPA.

This rule is not a major rule within the meaning of section 1(b) of E.O. 12291, and it does not have Federalism implications warranting the preparation of a Federalism Assessment in accordance with section 6 of E.O. 12612. This rule does not have a significant impact on a substantial number of small entities.

List of Subjects

28 CFR Part 50

Administrative practice and procedure, Foreign Corrupt Practices Act.

28 CFR Part 80

Administrative practice and procedure, Foreign Corrupt Practices Act.

By virtue of the authority vested in the Attorney General by 28 U.S.C. 509 and 510, 5 U.S.C. 301, and Public Law 100-418, chapter I of title 28 of the Code of Federal Regulations is amended as follows:

PART 50—STATEMENTS OF POLICY

1. The authority citation for part 50 continues to read as follows:

Authority: 5 U.S.C. 301, 552, 552a; 15 U.S.C. 16(d); 21 U.S.C. 881(f)(2); 28 U.S.C. 508, 509, 510, 516, 517, 518, 519; Executive Order 12250.

§ 50.18 [Removed]

2. Section 50.18 is removed and reserved.

3. Part 80 is added to read as follows:

PART 80—FOREIGN CORRUPT PRACTICES ACT OPINION PROCEDURE

Sec.

- § 80.1 Purpose.
- § 80.2 Submission requirements.
- § 80.3 Transaction.
- § 80.4 Issuer or domestic concern.
- § 80.5 Affected parties.
- § 80.6 General requirements.
- § 80.7 Additional information.
- § 80.8 Attorney General opinion.
- § 80.9 No oral opinion.
- § 80.10 Rebuttable presumption.
- § 80.11 Effect of FCPA Opinion.
- § 80.12 Accounting Requirements.
- § 80.13 Scope of FCPA Opinion.
- § 80.14 Disclosure.
- § 80.15 Withdrawal.
- § 80.16 Additional requests.

Authority: 28 U.S.C. 509, 510; 15 U.S.C. 78dd-1, 78dd-2.

§ 80.1 Purpose.

These procedures enable issuers and domestic concerns to obtain an opinion of the Attorney General as to whether certain specified, prospective—not hypothetical—conduct conforms with the Department's present enforcement policy regarding the antibribery provisions of the Foreign Corrupt Practices Act of 1977, as amended, 15 U.S.C. 78dd-1 and 78dd-2. An opinion issued pursuant to these procedures is a Foreign Corrupt Practices Act opinion (hereinafter FCPA Opinion).

§ 80.2 Submission requirements.

A request for an FCPA Opinion must be submitted in writing. An original and five copies of the request should be addressed to the Assistant Attorney General in charge of the Criminal Division, Attention: FCPA Opinion Group. The mailing address is P.O. Box 28188, Central Station, Washington, DC 20038. The address for hand delivery is room 2424, Bond Building, 1400 New York Avenue, NW., Washington, DC 20005.

§ 80.3 Transaction.

The entire transaction which is the subject of the request must be an actual—not a hypothetical—transaction but need not involve only prospective conduct. However, a request will not be considered unless that portion of the transaction for which an opinion is sought involves only prospective conduct. An executed contract is not a prerequisite and, in most—if not all—instances, an opinion request should be made prior to the requestor's commitment to proceed with a transaction.

§ 80.4 Issuer or domestic concern.

The request must be submitted by an issuer or domestic concern within the meaning of 15 U.S.C. 78dd-1 and 78dd-2, respectively, that is also a party to the transaction which is the subject of the request.

§ 80.5 Affected parties.

An FCPA Opinion shall have no application to any party which does not join in the request for the opinion.

§ 80.6 General requirements.

Each request shall be specific and must be accompanied by all relevant and material information bearing on the conduct for which an FCPA Opinion is requested and on the circumstances of the prospective conduct, including background information, complete copies of all operative documents, and detailed statements of all collateral or oral understandings, if any. The requesting issuer or domestic concern is under an affirmative obligation to make full and true disclosure with respect to the conduct for which an opinion is requested. Each request on behalf of a requesting issuer or corporate domestic concern must be signed by an appropriate senior officer with operational responsibility for the conduct that is the subject of the request and who has been designated by the requestor's chief executive officer to sign the opinion request. In appropriate cases, the Department of Justice may require the chief executive officer of each requesting issuer or corporate domestic concern to sign the request. All requests of other domestic concerns must also be signed. The person signing the request must certify that it contains a true, correct and complete disclosure with respect to the proposed conduct and the circumstances of the conduct.

§ 80.7 Additional information.

If an issuer's or domestic concern's submission does not contain all of the information required by § 80.6, the Department of Justice may request

whatever additional information or documents it deems necessary to review the matter. The Department must do so within 30 days of receipt of the opinion request, or, in the case of an incomplete response to a previous request for additional information, within 30 days of receipt of such response. Each issuer or domestic concern requesting an FCPA Opinion must promptly provide the information requested. A request will not be deemed complete until the Department of Justice receives such additional information. Such additional information, if furnished orally, shall be promptly confirmed in writing, signed by the same person or officer who signed the initial request and certified by this person or officer to be a true, correct and complete disclosure of the requested information. In connection with any request for an FCPA Opinion, the Department of Justice may conduct whatever independent investigation it believes appropriate.

§ 80.8 Attorney General opinion.

The Attorney General or his designee shall, within 30 days after receiving a request that complies with the foregoing procedure, respond to the request by issuing an opinion that states whether the prospective conduct, would, for purposes of the Department of Justice's present enforcement policy, violate 15 U.S.C. 78dd-1 and 78dd-2. The Department of Justice may also take such other positions or action as it considers appropriate. Should the Department request additional information, the Department's response shall be made within 30 days after receipt of such additional information.

§ 80.9 No oral opinion.

No oral clearance, release or other statement purporting to limit the enforcement discretion of the Department of Justice may be given. The requesting issuer or domestic concern may rely only upon a written FCPA Opinion letter signed by the Attorney General or his designee.

§ 80.10 Rebuttable presumption.

In any action brought under the applicable provisions of 15 U.S.C. 78dd-1 and 78dd-2, there shall be a rebuttable presumption that a requestor's conduct, which is specified in a request, and for which the Attorney General has issued an opinion that such conduct is in conformity with the Department's present enforcement policy, is in compliance with those provisions of the FCPA. Such a presumption may be rebutted by a preponderance of the evidence. In considering the

presumption, a court, in accordance with the statute, shall weigh all relevant factors, including but not limited to whether information submitted to the Attorney General was accurate and complete and whether the activity was within the scope of the conduct specified in any request received by the Attorney General.

§ 80.11 Effect of FCPA Opinion.

Except as specified in § 80.10, an FCPA Opinion will not bind or obligate any agency other than the Department of Justice. It will not affect the requesting issuer's or domestic concern's obligations to any other agency, or under any statutory or regulatory provision other than those specifically cited in the particular FCPA Opinion.

§ 80.12 Accounting requirements.

Neither the submission of a request for an FCPA Opinion, its pendency, nor the issuance of an FCPA Opinion, shall in any way alter the responsibility of an issuer to comply with the accounting requirements of 15 U.S.C. 78m(b)(2) and (3).

§ 80.13 Scope of FCPA Opinion.

An FCPA Opinion will state only the Attorney General's opinion as to whether the prospective conduct would violate the Department's present enforcement policy under 15 U.S.C. 78dd-1 and 78dd-2. If the conduct for which an FCPA Opinion is requested is subject to approval by any other agency, such FCPA Opinion shall in no way be taken to indicate the Department of Justice's views on the legal or factual issues that may be raised before that agency, or in an appeal from the agency's decision.

§ 80.14 Disclosure.

(a) Any document or other material which is provided to, received by, or prepared in the Department of Justice or any other department or agency of the United States in connection with a request by an issuer or domestic concern under the foregoing procedure shall be exempt from disclosure under 5 U.S.C. 552 and shall not, except with the consent of the issuer or domestic concern, be made publicly available, regardless of whether the Attorney General responds to such a request or the issuer or domestic concern withdraws such request before receiving a response.

(b) Nothing contained in paragraph (a) of this section shall limit the Department of Justice's right to issue, at its discretion, a release describing the identity of the requesting issuer or

domestic concern, the identity of the foreign country in which the proposed conduct is to take place, the general nature and circumstances of the proposed conduct, and the action taken by the Department of Justice in response to the FCPA Opinion request. Such release shall not disclose either the identity of any foreign sales agents or other types of identifying information. The Department of Justice shall index such releases and place them in a file available to the public upon request.

(c) A requestor may request that the release not disclose proprietary information.

§ 80.15 Withdrawal.

A request submitted under the foregoing procedure may be withdrawn prior to the time the Attorney General issues an opinion in response to such request. Any request so withdrawn shall have no force or effect. The Department of Justice reserves the right to retain any FCPA Opinion request, documents and information submitted to it under this procedure or otherwise and to use them for any governmental purposes, subject to the restrictions on disclosures in § 80.14.

§ 80.16 Additional requests.

Additional requests for FCPA Opinions may be filed with the Attorney General under the foregoing procedure regarding other prospective conduct that is beyond the scope of conduct specified in previous requests.

Dated: August 26, 1992.

William P. Barr,

Attorney General.

[FR Doc. 92-20914 Filed 8-31-92; 8:45 am]

BILLING CODE 4410-01-M

DEPARTMENT OF THE TREASURY

Fiscal Service

31 CFR Parts 315 and 353

Regulations Governing U.S. Savings Bonds, Series A, B, C, D, E, EE, F, G, H, HH, J, and K, and U.S. Savings Notes

AGENCY: Bureau of the Public Debt, Department of the Treasury.

ACTION: Final rule.

SUMMARY: This Final Rule amends the regulations governing savings bonds and savings notes to ease restrictions with respect to powers of attorney and voluntary guardians acting on behalf of incapacitated savings bond owners.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Dean A. Adams, Assistant Chief

Counsel, Bureau of the Public Debt, Parkersburg, West Virginia 26106-1328, (304) 420-6505.

SUPPLEMENTARY INFORMATION: The purpose of this final rule is to simplify the regulatory requirements in administering the savings bond program, and thereby provide cost savings to the Bureau and simpler procedures for bondowners and their representatives. As the provisions contained in parts 315, for Series E and H bonds and notes, and 353, for Series EE and HH bonds, are identical, the changes thereto are described together. The following changes have been made:

Payment Pursuant to a Power of Attorney

The current provisions on powers of attorney (§§ 315.40(d) and 315.65 and §§ 353.40(d) and 353.65) are being replaced with a new provision which would permit acceptance of a power of attorney for redemptions, exchanges, or reinvestments, if it provides authority to sell the grantor's securities or personal property, or otherwise contains language providing similar authority. The new sections require a power of attorney to conform with State law, particularly as it relates to durability and notarization.

Payments to Voluntary Guardians

Payments to voluntary guardians (§§ 315.64 and 353.64) have been simplified to permit payment of an incapacitated person's bonds or notes to a person recognized as his or her voluntary guardian, if the total redemption value of the bonds and notes belonging to such owner, on the date received by the Bureau, is \$20,000, or less. Currently, such securities may only be redeemed to pay expenses incurred during any 90-day period. Sections 315.65 and 353.65 are eliminated as it is no longer deemed necessary to provide separate rules for payment of savings bonds and notes upon the request of an attorney-in-fact where the owner is incompetent. The new provisions of §§ 315.64 and 353.64 apply to these latter redemptions as well. Accordingly, §§ 315.66 and 353.66 are redesignated §§ 315.65 and 353.65, respectively.

Procedural Requirements

This Final Rule is not considered a "major rule" for purposes of Executive Order No. 12291. A regulatory impact analysis, therefore, is not required. It has also been determined that Section 553 (b) of the Administrative Procedure Act (5 U.S.C. chapter 6) does not apply to these regulations. As no notice of

proposed rulemaking is required, the provisions of the Regulatory Flexibility Act (5 U.S.C. 601, *et seq.*) do not apply and a Regulatory Flexibility Analysis is not required.

List of Subjects in 31 CFR Parts 315 and 353

Banks and banking, Government securities, Federal reserve system.

Dated: August 25, 1992.

Gerald Murphy,

Fiscal Assistant Secretary.

31 CFR parts 315 and 353 are amended to read as follows:

PART 315—[AMENDED]

1. The authority citation for 31 CFR part 315 is revised to read as follows:

Authority: 31 U.S.C. 3105 and 5 U.S.C. 301.

2. Section 315.40(d) is revised to read as follows:

§ 315.40 Special provisions for payment.

(d) Attorneys-in-fact. A request for payment, reinvestment, or exchange executed by an attorney-in-fact will be recognized if it is accompanied by a copy of the power of attorney that meets the following requirements:

(1) The power of attorney must bear the grantor's signature, properly certified or notarized, in accordance with applicable State law;

(2) The power of attorney must grant, by its terms, authority for the attorney-in-fact to sell or redeem the grantor's securities, sell his or her personal property, or, otherwise contain similar authority; and

(3) In the case of a grantor who has become incapacitated, the power of attorney must conform with pertinent provisions of State law concerning its durability. Generally, in such circumstances, the power of attorney should provide that the authority granted will not be affected by the subsequent incompetence or incapacity of the grantor. Medical evidence or other proof of the grantor's condition may be required in any case.

3. Section 315.64 is revised to read as follows:

§ 315.64 Payment, reinvestment, or exchange—voluntary guardian of an incapacitated person.

(a) Payment of bonds. When an adult owner of bonds is incapable of requesting payment as a result of incapacity and there is no other person legally qualified to do so, the relative, or other person, responsible for the owner's care and support may submit an application for recognition as voluntary guardian for the purpose of redeeming

the owner's bonds, if the total redemption value of all of the owner's bonds does not exceed \$20,000. The redemption value of the bonds shall be determined as of the date the bonds are received, accompanied by an appropriate request for payment. If the total redemption value exceeds \$20,000, a legal representative must be appointed, as set forth in Section 315.60.

(b) Reinvestment of bonds. If the bonds have finally matured and it is desired to redeem them and reinvest the proceeds in other savings bonds, the new bonds must be registered in the name of the incapacitated person, followed by words showing that he or she is under voluntary guardianship; for example, "John Jones 123-45-6789, under voluntary guardianship". A living coowner or beneficiary named on the matured bonds must be designated on the new bonds, unless such person furnishes a certified statement consenting to omission of his or her name. If an amount insufficient to purchase an additional bond of any authorized denomination of either series remains after the reinvestment, the voluntary guardian may furnish additional funds sufficient to purchase another bond of either series of the lowest available denomination. If additional funds are not furnished, the remaining amount will be paid to the voluntary guardian for the use and benefit of the incapacitated person.

(c) Exchange of bonds. The provisions for reinvestment of the proceeds of matured bonds are equally applicable to any authorized exchange of bonds of one series for those of another.

§ 315.65 [Removed]

§ 315.66 [Redesignated as § 315.65]

4. Section 315.65 is removed and § 315.66 is redesignated as § 315.65.

PART 353—[AMENDED]

5. The authority citation for 31 CFR part 353 is revised to read as follows:

Authority: 31 U.S.C. 3105 and 5 U.S.C. 301.

6. Section 353.40 is amended by revising paragraph (d) to read as follows:

§ 353.40 Special provision for payment.

(d) Attorneys-in-fact. A request for payment, reinvestment, or exchange executed by an attorney-in-fact will be recognized if it is accompanied by a copy of the power of attorney which meets the following requirements:

(1) The power of attorney must bear the grantor's signature, properly

certified or notarized, in accordance with applicable State law;

(2) The power of attorney must grant, by its terms, authority for the attorney-in-fact to sell or redeem the grantor's securities, sell his or her personal property, or, otherwise contain similar authority; and

(3) In the case of a grantor who has become incapacitated, the power of attorney must conform with pertinent provisions of State law concerning its durability. Generally, in such circumstances, the power of attorney should provide that the authority granted will not be affected by the subsequent incompetence or incapacity of the grantor. Medical evidence or other proof of the grantor's condition may be required in any case.

7. Section 353.64 is revised to read as follows:

§ 353.64 Payment, reinvestment, or exchange—Voluntary guardian of an incapacitated person.

(a) Payment of bonds. When an adult owner of bonds is incapable of requesting payment as a result of incapacity and there is no other person legally qualified to do so, the relative, or other person, responsible for the owner's care and support may submit an application for recognition as voluntary guardian for the purpose of redeeming the owner's bonds, if the total redemption value of all of the owner's bonds does not exceed \$20,000. The redemption value of the bonds shall be determined as of the date the bonds are received, accompanied by an appropriate request for payment. If the total redemption value exceeds \$20,000, a legal representative must be appointed, as set forth in § 315.60.

(b) Reinvestment of bonds. If the bonds have finally matured and it is desired to redeem them and reinvest the proceeds in other savings bonds, the new bonds must be registered in the name of the incapacitated person, followed by words showing that he or she is under voluntary guardianship; for example, "John Jones 123-45-6789, under voluntary guardianship". A living coowner or beneficiary named on the matured bonds must be designated on the new bonds, unless such person furnishes a certified statement consenting to omission of his or her name. If an amount insufficient to purchase an additional bond of any authorized denomination of either series remains after the reinvestment, the voluntary guardian may furnish additional funds sufficient to purchase another bond of either series of the lowest available denomination. If

additional funds are not furnished, the remaining amount will be paid to the voluntary guardian for the use and benefit of the incapacitated person.

(c) Exchange of bonds. The provisions for reinvestment of the proceeds of matured bonds are equally applicable to any authorized exchange of bonds of one series for those of another.

§ 353.65 [Removed]

§ 353.66 [Redesignated as § 353.65]

8. Section 353.65 is removed and § 353.66 is redesignated as § 353.65.

[FR Doc. 92-20731 Filed 8-31-92; 8:45 am]

BILLING CODE 4810-10-M

Office of Foreign Assets Control

31 CFR Part 575

Iraqi Sanctions Regulations; Repeal of Reporting Requirement

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Final rule.

SUMMARY: In furtherance of the President's Regulatory Initiative, the Office of Foreign Assets Control is amending the Iraqi Sanctions Regulations by repealing § 575.603, which requires U.S. financial institutions to file monthly reports regarding certain bank accounts in which the Government of Iraq has an interest.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Dennis P. Wood, Chief, Compliance Programs Division, Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220, (202) 622-2490.

SUPPLEMENTARY INFORMATION: The Iraqi Sanctions Regulations, 31 CFR part 575 (the "Regulations"), were issued by the Treasury Department in implementation of Executive Order 12722 of August 2, 1990, and Executive Order 12724 of August 9, 1990, and United Nations Security Council Resolution 661 (August 6, 1990) and subsequent relevant resolutions. Section 575.603 of the Regulations requires U.S. financial institutions to file a monthly report concerning any bank account held by the institution in the name of a bank in which the Government of Iraq holds an equity interest of 10% or more. While this information was needed during the early implementation of the Regulations and for a period thereafter, it is no longer required on a monthly basis and can be obtained by the Treasury Department on a case-by-case basis as required. To implement the President's

Regulatory Initiative, this monthly reporting requirement is being eliminated.

Since the Regulations involve a foreign affairs function, the provisions of the Administrative Procedure Act, 5 U.S.C. 553, requiring notice of proposed rulemaking, opportunity for public participation, and delay in effective date, are inapplicable. Because no notice of proposed rulemaking is required for this rule, the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, does not apply. Because the Regulations are issued with respect to a foreign affairs function of the United States, they are not subject to Executive Order 12291 of February 17, 1981 dealing with Federal regulations.

List of Subject in 31 CFR Part 575

Administrative practice and procedure, Banks, Blocking of assets, Iraq, Reporting and recordkeeping requirements.

PART 575—IRAQI SANCTIONS REGULATIONS

For the reasons set forth in the preamble, 31 CFR part 575 is amended as set forth below:

1. The Authority citation for part 575 continues to read as follows:

Authority: 50 U.S.C. 1701 *et seq.*; 50 U.S.C. 1601 *et seq.*; 22 U.S.C. 287c; Pub. L. 101-513, 104 Stat. 2047-55 (Nov. 5, 1990); 3 U.S.C. 301; E.O. 12722, 55 FR 31803 (Aug. 3, 1990); E.O. 12724, 55 FR 33089 (Aug. 13, 1990).

Subpart F—Reports

§ 575.603 [Removed]

2. Section 575.603 is removed and reserved.

Dated: August 5, 1992.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: August 21, 1992.

Peter K. Nunez,

Assistant Secretary (Enforcement).

[FR Doc. 92-21117 Filed 8-28-92; 2:05 pm]

BILLING CODE 4801-25-M

31 CFR Part 580

Haitian Transactions Regulations

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Final rule; amendment.

SUMMARY: This rule amends the Haitian Transactions Regulations, 31 CFR part 580 (the "Regulations"), to give general authorization for the exportation of corn and corn flour, milk (including powdered milk) and edible tallow (*i.e.*, hardened shortening, including lard) from the

United States to Haiti, and indicating the availability, on a case-by-case basis, of specific licenses for the exportation from the United States to Haiti of propane for noncommercial use. The amendment increases the type of food items, initially specified in § 580.206 of the Regulations, that may be exported from the United States on a commercial basis.

EFFECTIVE DATE: This rule is effective on August 27, 1992.

FOR FURTHER INFORMATION CONTACT:

John T. Roth, Chief of Policy Planning and Program Management (tel. 202/622-1604), Steven I. Pinter, Chief of Licensing (tel. 202/622-2480), or William B. Hoffman, Chief Counsel (tel. 202/622-2410), Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220.

SUPPLEMENTARY INFORMATION: On March 31, 1992, the Department of the Treasury promulgated the Haitian Transactions Regulations in consultation with the Department of State to implement the President's Executive Orders of October 4, 1991, declaring a national emergency with respect to Haiti and ordering specified measures against Haiti, and of October 28, 1991, ordering a trade embargo against Haiti. A new § 580.516 is added. Section 580.516(a) gives general authorization for the exportation from the United States to Haiti of corn and corn flour, milk (including powdered milk) and edible tallow (*i.e.*, hardened shortening, including lard). Section 580.516(b) provides that specific licenses are available on a case-by-case basis for the exportation from the United States to Haiti of propane for noncommercial use.

Because the Regulations involve a foreign affairs function, Executive Order 12291 and the provisions of the Administrative Procedure Act, 5 U.S.C. 553, requiring notice of proposed rulemaking, opportunity for public participation, and delay in effective date, are inapplicable. Because no notice of proposed rulemaking is required for this rule, the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, does not apply.

List of Subjects in 31 CFR Part 580

Administrative practice and procedure, Banking and finance, Blocking of assets, Exports, Haiti, Imports, Penalties, Reporting and recordkeeping requirements, Shipping, Transfer of assets, Vessels.

For the reasons set forth in the preamble, 31 CFR part 580 is amended as follows:

PART 580—HAITIAN TRANSACTIONS REGULATIONS

1. The authority citation for part 580 continues to read as follows:

Authority: 50 U.S.C. 1701, *et seq.*; E.O. 12775, 56 FR 50641 (Oct. 7, 1991); E.O. 12779, 56 FR 55975 (Oct. 30, 1991).

Subpart E—Licenses, Authorizations and Statements of Licensing Policy

2. Section 580.516 is added to read as follows:

§ 580.516 Shipments to Haiti of Certain Foodstuffs and Propane.

(a) The exportation from the United States to Haiti of corn and corn flour, milk (including powdered milk), and edible tallow (*i.e.*, hardened shortening, including lard) is authorized. No payments to the *de facto* regime in Haiti in connection with such export transactions are authorized.

(b) Specific licenses may be issued on a case-by-case basis authorizing the exportation from the United States to Haiti of propane for noncommercial use. Applicants for licenses should describe the controls, if any, that would be exercised by the importer in Haiti to ensure that the propane imported into Haiti pursuant to the license would not be diverted to other uses.

Dated: August 17, 1992.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: August 20, 1992.

John P. Simpson,

Acting Assistant Secretary (Enforcement).

[FR Doc. 92-20950 Filed 8-27-92; 11:46 am]

BILLING CODE 4810-25-M

CENTRAL INTELLIGENCE AGENCY**32 CFR Part 1906****Enforcement of Nondiscrimination on the Basis of Handicap in Programs or Activities Conducted by the Central Intelligence Agency**

AGENCY: Central Intelligence Agency.

ACTION: Final rule.

SUMMARY: This regulation requires that the Central Intelligence Agency operate all of its programs and activities to ensure nondiscrimination against qualified individuals with handicaps. It sets forth standards for what constitutes discrimination on the basis of mental or physical handicap, provides a definition for individual with handicaps and qualified individual with handicaps, and establishes a complaint mechanism for resolving allegations of discrimination. This regulation is issued under the

authority of section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap in programs or activities conducted by Federal Executive Agencies.

EFFECTIVE DATE: November 2, 1992.

ADDRESSES: Comments received on the Notice of Proposed Rulemaking will remain available with the Office of General Counsel, Central Intelligence Agency, Washington, DC 20505. Copies of this regulation will be made available on tape for persons with impaired vision who request them.

FOR FURTHER INFORMATION CONTACT: Cynthia Drabek, (703) 874-3150.

SUPPLEMENTARY INFORMATION: The purpose of this rule is to provide for the enforcement of section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), as it applies to programs and activities conducted by the Central Intelligence Agency (herein "the Agency"). As amended by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act Amendments of 1978 (Sec. 119, Pub. L. 95-602, 92 Stat. 2982) and the Rehabilitation Act Amendments of 1986 (Pub. L. 99-506, 100 Stat. 1810), section 504 of the Rehabilitation Act of 1973 states that:

No otherwise qualified individual with handicaps in the United States * * * shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive Agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees. (29 U.S.C. 794) (1978 Amendment italicized).

On February 16, 1989, the Agency published a Notice of Proposed Rulemaking (NPRM) in the Federal Register, 54 FR 7056. The period for receiving public comment expired April 17, 1989. The Agency received one comment from a national interest organization and none from individuals. After analysis of the comment, the Agency decided to adopt this final rule. The NPRM proposed a new part 1904. Due to the delay in publication of this final rule, this rule is being published as part 1906, and section numbers from the

proposed rule have been adapted accordingly.

Section 504 requires that regulations that apply to the programs and activities of Federal Executive agencies shall be submitted to the appropriate authorizing committees of Congress and that such regulations may take effect no earlier than the thirtieth day after they have been so submitted. The Agency is submitting these regulations to the Senate Committee on Labor and Human Resources and its Subcommittee on the Handicapped and to the House Committee on Education and Labor and its Subcommittee on Select Education. The regulation will become effective on November 25, 1992.

The substantive nondiscrimination obligations of the Agency, as set forth in this rule, are identical, for the most part, to those established by Federal regulations for programs or activities receiving Federal financial assistance. (See 28 CFR part 41, the section 504 coordination regulation for federally assisted programs). This general parallelism is in accord with the intent expressed by supporters of the 1978 amendment in floor debate, including its sponsor, Rep. James M. Jeffords, that the Federal Government should have the same section 504 obligations as recipients of Federal financial assistance. 124 Cong. Rec. 13,901 (1978) (remarks of Rep. Jeffords); 124 Cong. Rec. E2668 (daily ed. May 17, 1978) 38,552 (remarks of Rep. Sarasin).

The Agency has proposed a slightly modified version of rules to provide for the enforcement of section 504 of the Rehabilitation Act of 1973, as amended. The purpose of the variation is to assure that the amendment is enforced, as applied to the Central Intelligence Agency, in a manner consistent with the Agency's mission; the National Security Act of 1947 (50 U.S.C. 402 *et seq.*), as amended; and other applicable law. The commenter objected to language differences between this rule and the Federal Government's section 504 regulations for federally assisted programs. As explained in the preamble to the proposed rule, these changes are based on the Supreme Court's decision in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), and the subsequent circuit court decisions interpreting *Davis* and section 504. See, *Dopico v. Goldschmidt*, 687 F. 2d 664 (2d Cir. 1982); *American Public Transit Association v. Lewis*, 655 F.2d 1272 (D.C. Cir. 1981) (APTA); see also *Rhode Island Handicapped Action Committee v. Rhode Island Public Transit Authority*, 718 F. 2d 490 (1st Cir. 1983).

These language differences are also supported by the decision of the Supreme Court in *Alexander v. Choate*, 469 U.S. 287 (1985), in which the Court held that the regulations for federally assisted programs did not require a recipient to modify its durational limitation on Medical coverage of inpatient hospital care for handicapped persons. Clarifying its *Davis* decision, the Court explained that section 504 requires only "reasonable" modifications, *id.* at 300, and explicitly noted that "(the) regulations implementing section 504 [for federally assisted programs] are consistent with the view that reasonable adjustments in the nature of the benefit offered must at times be made to assure meaningful access" *id.* 301 n. 21 (emphasis added).

Incorporation of these changes, therefore, makes this regulation implementing section 504 for federally conducted programs consistent with the Federal Government's regulations implementing section 504 for federally assisted programs as they have been interpreted by the Supreme Court. Many of these federally assisted regulations were issued prior to the interpretations of section 504 by the Supreme Court in *Davis*, by lower courts interpreting *Davis*, and by the Supreme Court in *Alexander*; therefore, their language does not reflect the interpretation of section 504 provided by the Supreme Court and by the various circuit courts. Thus, because the Agency interprets the federally assisted regulations to reflect the judicial rulings described earlier, the Agency believes that there are no significant differences between this proposed rule for federally conducted programs and the Federal Government's interpretation of section 504 regulations for federally assisted programs.

This regulation has been reviewed by the Department of Justice. It is an adaptation of a prototype prepared by the Department of Justice under Executive Order 12250 (45 FR 72995, 3 CFR, 1980 Comp., p. 298) and distributed to Executive Agencies. This regulation has also been reviewed by the Equal Employment Opportunity Commission under Executive Order 12067 (43 FR 28967, 3 CFR, 1978 Comp., p. 206).

Executive Order 12291

These regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulation established in the Order.

Regulatory Flexibility Act Certification

The Director of Central Intelligence Agency certifies that these regulations

would not have a significant economic impact on a substantial number of small entities. These regulations apply only to programs or activities conducted by the Central Intelligence Agency.

Section-by-Section Analysis and Response to Comments

Section 1906.101 Purpose

Section 1906.01 states the purpose of the rule, which is to effectuate section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which amended section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of handicap in programs or activities conducted by Executive agencies or the United States Postal Service.

Section 1906.102 Application

The regulation applies to all programs or activities conducted by the Agency. Under this section, a federally conducted program or activity is, in simple terms, anything a federal agency does. Aside from employment, there are two major categories of federally conducted programs or activities covered by this regulation: Those involving general public contact as part of ongoing Agency operations and those directly administered by the Agency for program beneficiaries and participants. Activities in the first category include communication with the public (telephone contacts, office walk-ins, or interviews) and the public's use of the Agency's facilities. Activities in the second category include programs that provide Federal services or benefits. This regulation does not, however, apply to programs or activities conducted outside the United States that do not involve individuals with handicaps in the United States. This regulation will apply to the Agency only to the extent consistent with the National Security Act of 1947 (50 U.S.C. 402 *et seq.*) as amended; the Central Intelligence Agency Act of 1949 (50 U.S.C. 403a *et seq.*) as amended; and other applicable law. Nor shall anything in the regulation be deemed to impair the Director's responsibility for protecting intelligence sources and methods.

Section 1906.103 Definitions

"Assistant Attorney General" means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

"Auxiliary Aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to

participate and enjoy the benefits of the Agency's programs or activities. The definition provides examples of commonly used auxiliary aids. Although auxiliary aids are required explicitly only by § 1906.160(a)(1), they also may be necessary to meet other requirements of the regulation. The Agency may prohibit from any of its facilities any auxiliary aid, or category of auxiliary aid, that the Office of Security (OS) determines creates a security risk. OS reserves the right to examine any auxiliary aid brought into an Agency facility.

The commenter suggested that the requirement for auxiliary aids in the aspects of the Agency's program other than those covered by § 1906.160(a)(1) should be specifically stated in the regulation. The Agency believes that such a statement is unnecessary, because the regulation makes the obligation not to discriminate clear and thus requires the provision of auxiliary aids whenever they are necessary to meet that obligation. The commenter suggested that "attendant services" should be included in the list of examples of auxiliary aids appearing in the definition. The Agency believes that attendant services are generally personal in nature and that they are therefore generally not required. It was also suggested that the definition of auxiliary aids be expected to include aids for people with physical impairments, and that the term auxiliary be changed to "aids for reasonable accommodation." The Agency retains the definition and terminology of the proposed rule in order to be consistent with similar regulations issued government-wide.

"Complete complaint." "Complete complaint" is defined to include all the information necessary to enable the Agency to investigate the complaint. The definition is necessary because the 180 day period for the Agency's investigation (*see* § 1906.170(g)) begins when it receives a complete complaint.

"Director" refers to the Director of Central Intelligence or an official or employee of the Agency acting for the Director under a delegation of authority.

"Facility." The definition of "facility" is similar to that in the section 504 coordination regulation for federally assisted programs, 28 CFR 41.3(f) except that the term "rolling stock or other conveyances" has been added and the phrase, "or interest in such property," is deleted because the term "facility," as used in this regulation, refers to structures and not to intangible property rights.

"Individual with handicaps." The definition of "individual with handicaps" is identical to the definition of "handicapped person" appearing in the section 504 coordination regulation for federally assisted programs (28 CFR 41.31). Although section 203(d) of the Rehabilitation Act Amendments of 1986 changed the statutory term "handicapped individual" to "individual with handicaps," the legislative history of this amendment indicates that no substantive change was intended. Thus, although the term has been changed in this regulation to be consistent with the statute, as amended, the definition is unchanged. In particular, although the term as revised refers to "handicaps" in the plural, it does not exclude persons who have only one handicap.

"Qualified individual with handicaps." The definition of "qualified individual with handicaps" is a revised version of the definition of "qualified handicapped person" appearing in the section 504 coordination regulation for federally assisted programs (28 CFR 41.32).

Paragraph (1) deviates from existing regulations for federally assisted programs because of intervening court decisions. It defines "qualified individual with handicaps" with regard to any program under which a person is required to perform services or to achieve a level of accomplishment. In those programs, a qualified individual with handicaps is one who can achieve the purpose of the program without modifications in the program that the Agency can demonstrate would result in a fundamental alteration in its nature. This definition reflects the decision of the Supreme Court in *Davis*. In that case, the Court ruled that a hearing impaired applicant to a nursing school was not a "qualified handicapped person" because her hearing impairment would prevent her from participating in the clinical training portion of the program. The Court found that, if the program were modified so as to enable the respondent to participate (by exempting her from the clinical training requirements), "she would not receive even a rough equivalent of the training a nursing program normally gives." *Id.* at 410. It also found that "the purpose of [the] program was to train persons who could serve the nursing profession in all customary ways," *Id.* at 413, and that the respondent would be unable, because of her hearing impairment, to perform some functions expected of a registered nurse. It, therefore, concluded that the school was not required by section 504 to make such modifications that would result in "a fundamental

alteration in the nature of the program." *Id.* at 410.

We have incorporated the Court's language in the definition of "qualified individual with handicaps" in order to make clear that such a person must be able to participate in the program offered by the Agency. The Agency is required to make modifications in order to enable an applicant with handicaps to participate, but is not required to offer a program of a fundamentally different nature. The test is whether, with appropriate modifications, the applicant can achieve the purpose of the program offered; not whether the applicant would benefit or obtain results from some other program that the Agency does not offer. Although the revised definition allows exclusion of some individuals with handicaps from some programs, it requires that an individual with handicaps who is capable of achieving the purpose of the program must be accommodated, provided that the modifications do not fundamentally alter the nature of the program.

The commenter argued that this definition of "qualified individual with handicaps" was unnecessary, because *Davis* was an interpretation of the definition in paragraph (2), which requires only that the individual meet "the essential eligibility requirements" for participation in the program. The Agency believes that *Davis* clarifies the meaning of "essential eligibility requirements" with respect to programs, such as the one at issue in that case, in which an individual, "is required to perform services or to achieve a level of accomplishment." In such a program, the Court held in *Davis*, an individual is not qualified if he or she cannot achieve the purpose of the program without modifications that would fundamentally alter its nature. The Agency believes that it is appropriate to reflect this clarification in the regulation.

The commenter also suggested that the rule rather than the preamble should address when modifications to a program must occur. The Agency believes that the obligation to make appropriate modifications or adjustments to enable individuals with handicaps to participate in its programs is made sufficiently clear in the substantive provisions of the regulation, so that a reference to it in this definition is unnecessary.

The Agency has the burden of demonstrating that a proposed modification would constitute a fundamental alteration in the nature of its program or activity. Furthermore, in demonstrating that a modification would result in such an alteration, the Agency

must follow the procedures established in §§ 1906.150(a) and 1906.160(d), which are discussed below, for demonstrating that an action would result in undue financial and administrative burdens. That is, the decision must be made by the Director or his or her designee in writing after consideration of all resources available for the program or activity and must be accompanied by an explanation of the reasons for the decision. If the Director determines that an action would result in a fundamental alteration, the Agency must consider options that would enable the individual with handicaps to achieve the purpose of the program but would not result in such an alteration.

For programs or activities that do not fall under the first paragraph, paragraph (2) adopts the existing definition of "qualified handicapped person" with respect to services (28 CFR 41.32(b)) in the coordination regulation for programs receiving Federal financial assistance. Under this definition, a qualified individual with handicaps is an individual with handicaps who meets the essential eligibility requirements for participation in the program or activity.

Paragraph (3) explains that "qualified individual with handicaps" means "qualified handicapped person" as that term is defined for purposes of employment in the Equal Employment Opportunity Commission's regulation at 29 CFR 1613.702(f), which is made applicable to this part by § 1906.140. Nothing in this part changes existing regulations applicable to employment.

"Section 504." This definition makes clear that, as used in this regulation, "Section 504" applies only to programs or activities conducted by the Agency and not to programs or activities to which it provides Federal financial assistance.

Section 1906.110 Self-evaluation

The Agency shall conduct a self-evaluation of its compliance with section 504 within one year of the effective date of this regulation. The self-evaluation requirement is present in the existing section 504 coordination regulation for programs or activities receiving Federal financial assistance (28 CFR 41.5(b)(2)). Experience has demonstrated the self-evaluation process to be a valuable means of establishing a working relationship with individuals with handicaps that promotes both effective and efficient implementation of section 504.

Section 1906.111 Notice

Section 1906.111 requires the Agency to disseminate sufficient information to

employees, applicants, participants, beneficiaries, and other interested persons to apprise them of rights and protections afforded by section 504 and this regulation. Methods of providing this information include, for example, the publication of information in handbooks, manuals, and pamphlets that are distributed to the public to describe the Agency's programs and activities; the display of informative posters in service centers and other public places; or the broadcast of information by television or radio.

Section 1906.130 General prohibitions against discrimination

Section 1906.130 is an adaptation of the corresponding section of the section 504 coordination regulation for programs or activities receiving Federal financial assistance (28 CFR 41.51).

Paragraph (a) restates the nondiscrimination mandate of section 504. The remaining paragraphs in § 1906.130 establish the general principles for analyzing whether any particular action of the Agency violates this mandate. These principles serve as the analytical foundation for the remaining sections of the regulation. If the Agency violates a provision in any of the subsequent sections, it will violate one of the general prohibitions found in § 1906.130. If there is no applicable subsequent provision, the general prohibitions stated in this section apply.

Paragraph (b) of this section prohibits overt denials of equal treatment of individuals with handicaps. The Agency may not refuse to provide an individual with an equal opportunity to participate in or benefit from its program simply because the person is handicapped. Such blatantly exclusionary practices often result from the use of irrebuttable presumptions that absolutely exclude certain classes of disabled persons (e.g., epileptics, hearing-impaired persons, persons with heart ailments) from participation in programs or activities without regard to an individual's actual ability to participate. Use of an irrebuttable presumption is permissible only when in all cases a physical condition by its very nature would prevent an individual from meeting the essential eligibility for participation in the program or activity in question. It would be permissible, therefore, to exclude, without an individual evaluation, all persons who are blind in both eyes from eligibility for a license to operate a commercial vehicle in interstate commerce; but it may not be permissible to disqualify automatically all those who are blind in just one eye.

In addition, section 504 prohibits more than just the most obvious denials of

equal treatment. It is not enough to admit persons in wheelchairs to a program if the facilities in which the program is conducted are inaccessible. Paragraph (b)(1)(iii), therefore, requires that the opportunity to participate or benefit afforded to an individual with handicaps be as effective as that afforded to others. The later sections on program accessibility (§§ 1906.149-1906.151) and communications (§ 1906.160) are specific applications of this principle.

Despite the mandate of paragraph (d) that the Agency administer its programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps, paragraph (b)(1)(iv), in conjunction with paragraph (d), permits the Agency to develop separate or different aids, benefits, or services if necessary to provide individuals with handicaps with an equal opportunity to participate in or benefit from the Agency's programs or activities. Paragraph (b)(1)(iv) requires that different or separate aids, benefits, or services be provided only if necessary to ensure that the aids, benefits, or services are as effective as those provided to others. Even if separate aids, benefits, or services would be more effective, paragraph (b)(2) provides that a qualified individual with handicaps still has the right to choose to participate in the program or activity that is not designed to accommodate individuals with handicaps.

Paragraph (b)(1)(v) prohibits the Agency from denying a qualified individual with handicaps the opportunity to participate as a member of a planning or advisory board.

Paragraph (b)(1)(vi) prohibits the Agency from denying a qualified individual with handicaps in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving any aid, benefit, or service.

Paragraph (b)(3) prohibits the Agency from utilizing criteria or methods of administration that deny individuals with handicaps access to the Agency's programs or activities. The phrase "criteria or methods of administration" refers to official written Agency policies and to the actual practices of the Agency. This paragraph prohibits both blatantly exclusionary policies or practices and nonessential policies and practices that are neutral on their face, but deny individuals with handicaps an effective opportunity to participate.

Paragraph (b)(4) specifically applies the prohibition enunciated in § 1906.130(b)(3) to the process of selecting sites for construction of new

facilities or existing facilities to be used by the Agency. Paragraph (b)(4) does not apply to construction of additional buildings at an existing site.

Paragraph (b)(5) prohibits the Agency, in the selection of procurement contractors, from using criteria that subject qualified individuals with handicaps to discrimination on the basis of handicap.

Paragraph (b)(6) prohibits the Agency from discriminating against qualified individuals with handicaps on the basis of handicap in the granting of licenses or certification. A person is a "qualified individual with handicaps" with respect to licensing or certification if he or she can meet the essential eligibility requirements for receiving the license or certification (see § 1906.103).

In addition, the Agency may not establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with handicaps to discrimination on the basis of handicaps. For example, the Agency must comply with this requirement when establishing safety standards for the operations of licensees. In that case, the Agency must ensure that standards that it promulgates do not discriminate against the employment of qualified individuals with handicaps in an impermissible manner.

Paragraph (b)(6) does not extend section 504 directly to the programs or activities of licensees or certified entities themselves. The programs or activities of Federal licensees or certified entities are not themselves federally conducted programs or activities nor are they programs or activities receiving Federal financial assistance merely by virtue of the Federal license or certificate. However, as noted, above, section 504 may affect the content of the rules established by the Agency for the operation of the program or activity of the licensee or certified entity, and thereby indirectly affect limited aspects of their operations.

The commenter recommended that the Agency include in its final regulation the provision on the licensing and certification from regulations issued by other agencies that provide federal financial assistance. That provision was not included in the proposed rule and is not included in this final rule because it is not applicable to the Agency's programs.

Similarly, this regulation does not include the paragraph of the regulations for federally assisted programs that prohibits a recipient from providing significant assistance to an organization

that discriminates. To the extent that assistance from the Agency would provide significant support to an organization, it would constitute Federal financial assistance, and the organization as a recipient of such assistance would be covered by section 504's provisions applicable to federally assisted programs. The regulatory "significant assistance" provision, however, would be inappropriate in a regulation applying only to federally conducted programs or activities.

Paragraph (c) provides that programs conducted pursuant in Federal statute or Executive order that are designed to benefit only individuals with handicaps or a given class of individuals with handicaps may be limited to those individuals with handicaps.

Paragraph (d), discussed above, provides that the Agency must administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps, i.e., in a setting that enables individuals with handicaps to interact with non-handicapped persons to the fullest extent possible.

Section 1906.140 Employment

Section 1906.140 prohibits discrimination on the basis of handicap in employment by the Agency. Courts have held that section 504, as amended in 1978, covers the employment practices of Executive agencies. *Gardner v. Morris*, 752 F.2d 1271, 1277 (8th Cir. 1985); *Smith v. U.S. Postal Service*, 742 F.2d 257, 259-260 (8th Cir. 1984); *Prewitt v. United States Postal Service*, 662 F.2d 292, 302-04 (5th Cir. 1981). *Contra McGuinness v. U.S. Postal Service*, 744 F.2d 1318, 1320-04 (7th Cir. 1984); *Boyd v. U.S. Postal Service*, 752 F.2d 410, 413-14 (9th Cir. 1985).

Courts uniformly have held that, in order to give effect to section 501 of the Rehabilitation Act, which covers Federal employment, the administrative procedures of section 501 must be followed in processing complaints of employment discrimination under section 504. *Smith*, 742 F.2d at 262; *Prewitt*, 662 F.2d at 304. Accordingly, § 1906.140 (Employment) of this rule adopts the definitions, requirements, and procedures of section 501 as established in regulations of the Equal Employment Opportunity Commission (EEOC) at 29 CFR part 1613. Responsibility for coordinating enforcement of Federal laws prohibiting discrimination in employment is assigned to the EEOC by Executive Order 12067 (3 CFR part 1978 Comp., p. 206). Under this authority, the EEOC establishes government-wide standards on nondiscrimination in employment on

the basis of handicap. In addition to this section, § 1906.170(b) specifies that the Agency will use the existing EEOC procedures to resolve allegations of employment discrimination.

Section 1906.149 Program accessibility: Discrimination prohibited

Section 1906.149 states the general nondiscrimination principle underlying the program accessibility requirements of §§ 1906.150 and 1906.151.

Section 1906.150 Program accessibility: Existing facilities

This regulation adopts, with certain modification, the program-accessibility concept found in the existing section 504 coordination regulation for programs or activities receiving Federal financial assistance (28 CFR 41.57). Thus, § 1906.150 requires that each Agency program or activity, when viewed in its entirety, be readily accessible to and usable by individuals with handicaps. The regulation also makes clear that the Agency is not required to make each of its existing facilities accessible (§ 1906.150(a)(1)). However, § 1906.150, unlike 28 CFR 41.57, places explicit limits on the Agency's obligation to ensure program accessibility (§ 1906.150(a)(2)).

Paragraph (a)(2) generally codifies recent case law that defines that scope of the Agency's obligation to ensure program accessibility. This paragraph provides that in meeting the program accessibility requirement the Agency is not required to take any action that would result in a fundamental alteration in the nature of its program or activity or in undue financial and administrative burdens. A similar limitation is provided in § 1906.160(d). This provision is based on the Supreme Court's holding in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), that section 504 does not require modifications that would result in "undue financial and administrative burdens." 442 U.S. at 412. Since *Davis*, circuit courts have applied this limitation on a showing that only one of the two "undue burdens" would be created as a result of the modification sought to be imposed under section 504. See e.g., *Dopico v. Goldschmidt*, 687 F.2d 644 (2d Cir. 1982); *American Public Transit Association v. Lewis (APTA)*, 655 F.2d 1272 (D.C. Cir. 1981).

Paragraph (a)(2) and § 1906.160(d) are also supported by the Supreme Court's decision in *Alexander v. Choate*, 469 U.S. 287 (1985). *Alexander* involved a challenge to the State of Tennessee's reduction of inpatient hospital care coverage under Medicaid from 20 to 14 days per year. Plaintiffs argued that this

reduction violated section 504 because it had an adverse impact on handicapped persons. The Court assumed without deciding that section 504 reaches at least some conduct that has an unjustifiable disparate impact on handicapped people, but held that the reduction was not "the sort of disparate impact" discrimination that might be prohibited by section 504 or its implementing regulation. *Id.* at 299.

Relying on *Davis*, the Court said that section 504 guarantees qualified handicapped persons "meaningful access to the benefits that the grantee offers," *Id.* at 301, and that "reasonable adjustments in the nature of the benefits being offered must at times be made to assure meaningful access." *Id.* at n. 21 (emphasis added). However, section 504 does not require "changes," "adjustments," or "modifications" to existing programs that would be "substantial" * * * or that would constitute "fundamental alteration[s] in the nature of a program." *Id.* at n. 20 (citations omitted). *Alexander* supports the position, based on *Davis* and the earlier, lower court decisions, that in some situation, certain accommodations for a handicapped person may so alter an agency's program or activity, or entail such extensive costs and administrative burdens that the refusal to undertake the accommodations is not discriminatory. Thus, failure to include such an "undue burdens" provision could lead to judicial invalidation of the regulation or reversal of a particular enforcement action taken pursuant to the regulation.

This paragraph, however, does not establish an absolute defense; it does not relieve the Agency of all obligations to individuals with handicaps. Although the Agency is not required to take actions that would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens, it nevertheless must take any other steps necessary to ensure that individuals with handicaps receive the benefits and services of the federally conducted program or activity.

It is the Agency's view that compliance with § 1906.150(a) would in most cases not result in undue financial and administrative burdens on the Agency. In determining whether financial and administrative burdens are undue, all of the Agency's resources available for use in the funding and operation of the conducted program or activity should be considered. The burden of proving that compliance with § 1906.150(a) would fundamentally alter the nature of a program or activity, or

would result in undue financial and administrative burdens, rests with the Agency. The decision that compliance would result in that alteration, or those burdens, must be made by the Director, or his or her designee, and must be accompanied by a written statement of the reasons for reaching that conclusion. Any person who believes that he or she or any specific class of persons has been injured by the Director's decision, or failure to make a decision, may file a complaint under the compliance procedures established in § 1906.170.

Paragraph (b)(1) sets forth a number of means by which program accessibility may be achieved, including redesign of equipment, reassignment of services to accessible buildings, and provision of aides. In choosing among methods, the Agency shall give priority consideration to those that will be consistent with provision of services in the most integrated setting appropriate to the needs of individuals with handicaps. Structural changes in existing facilities are required only when there is no other feasible way to make the Agency's program accessible. (It should be noted that "structural changes" include all physical changes to a facility; the term does not refer only to changes to structural features, such as removal of or alterations to a load-bearing structural member.) The Agency may comply with the program accessibility requirement by delivering services at alternate accessible sites or making home visits as appropriate.

Paragraphs (c) and (d) establish time periods for complying with the program accessibility requirement. As currently required for federally assisted programs by 28 CFR 41.57(b), the Agency must make any necessary structural changes in facilities as soon as practicable, but in no event later than three years after the effective date of this regulation. If structural modifications are required, a transition plan must be developed within six months of the effective date of this regulation. Aside from structural changes, all other necessary steps to achieve compliance must be taken within 60 days.

Section 1906.151 Program accessibility: New construction and alterations

Overlapping coverage exists with respect to new construction and alterations under section 504 and the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151-4157). Section 1906.151 provides that those buildings that are constructed or altered by, on behalf of, or for the use of the Agency must be designed, constructed, or altered to be readily accessible to and

usable by individuals with handicaps in accordance with 41 CFR 101-19.600 to 101-19.607. This standard was promulgated pursuant to the Architectural Barriers Act standard of section 504 compliance because new and altered buildings subject to this regulation are also subject to the Architectural Barriers Act and because adoption of the standard will avoid duplicative and possibly inconsistent standards.

Existing buildings leased by the Agency after the effective date of this regulation are not required by the regulation to meet accessibility standards simply by virtue of being leased. They are subject, however, to the program accessibility standards for existing facilities in § 1906.150. To the extent that buildings are newly constructed or altered, they must also meet the new construction and alteration requirements of § 1906.151.

Federal practice under section 504 has always treated newly leased buildings as subject to the existing facility program accessibility standard. Unlike the construction of new buildings where architectural barriers can be avoided at little or no cost, the application of new construction standards to an existing building being leased raises the same prospect of retrofitting buildings as the use of an existing Federal facility, and the Agency believes the same program accessibility standard should apply to both owned and leased existing buildings.

In *Rose v. United States Postal Service*, 744 F.2d 1335 (9th Cir. 1985), the Ninth Circuit held that the Architectural Barriers Act requires accessibility at the time of lease. The *Rose* court did not address whether section 504 likewise requires accessibility as a condition of lease, and the case was remanded in the District Court for, among other things, consideration of that issue. The Agency may provide more specific guidance on section 504 requirements for leased buildings after the litigation is completed.

Section 1906.160 Communications

Section 1906.160 requires the Agency to take appropriate steps to ensure effective communication with personnel of other Federal entities, applicants, participants, and members of the public. These steps must include procedures for determining whether auxiliary aids are necessary under § 1906.160(a)(1) to afford an individual with handicaps an equal opportunity to participate in, and enjoy the benefits of, the Agency's program or activity. They must also include an opportunity for individuals

with handicaps to request the auxiliary aids of their choice. This expressed choice must be given primary consideration by the agency (§ 1906.160(a)(1)(i)). The Agency shall honor the choice unless it can demonstrate that another effective means of communication exists or that use of the means chosen would not be required under § 1906.160(d). That paragraph limits the obligation of the agency to ensure effective communication in accordance with *Davis* and the circuit court opinions interpreting it (see *supra* preamble discussion of § 1906.150(a)(3)). Unless not required by § 1906.160(d), the Agency shall provide auxiliary aids at no cost to the individual with handicaps.

The discussion of § 1906.150(a), Program accessibility: Existing facilities, regarding the determination of undue financial and administrative burdens, also applies to this section and should be referred to for a complete understanding of the Agency's obligation to comply with § 1906.160. The commenter argued that the decision that an action would result in undue burdens should be based on the resources of the Agency as a whole. The Agency believes that its entire budget is an inappropriate touchstone for making determinations as to undue financial and administrative burdens. Parts of the Agency's budget may be earmarked for specific purposes and may simply not be available for use in making the Agency's programs accessible to individuals with handicaps.

Section 1906.170 Compliance Procedures

Paragraph (a) specifies that paragraphs (c) through (l) of this section establish the procedures for processing complaints other than employment complaints. Paragraph (b) provides that the Agency will process employment complaints according to procedures established in existing regulations of the EEOC (29 CFR part 1613) pursuant to section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791).

Paragraph (c) designates the Director, Office of Equal Employment Opportunity, as the official responsible for coordinating implementation of this section. Complaints may be sent to the Central Intelligence Agency, Director, Office of Equal Employment Opportunity, Washington, DC 20505.

The Agency is required to accept and investigate all complete complaints (§ 1906.370(d)). If it determines that it does not have jurisdiction over a complaint, it shall promptly notify the complainant and make reasonable

efforts to refer the complaint to the appropriate entity of the Federal Government (§ 1906.170(e)).

Paragraph (f) requires the Agency to notify the Architectural and Transportation Barriers Compliance Board upon receipt of a complaint alleging that a building or facility subject to the Architectural Barriers Act was designed, constructed, or altered in a manner that does not provide ready access to and use by individuals with handicaps. The commenter suggested a provision for obtaining the expertise of the Architectural and Transportation Barriers Compliance Board to resolve deficiencies in construction or location of facilities. The process of notifying the Barriers Compliance Board includes the assumption that the Agency will consult experts on barriers free design at the Compliance Board and at all other appropriate resources.

Paragraph (g) requires the Agency to provide to the complainant, in writing, findings of fact and conclusions of law the relief granted if noncompliance is found, and notice of the right to appeal (§ 1906.170(g)). One appeal within the Agency must be provided (§ 1906.170(i)). The appeal will not be heard by the same person who made the initial determination of compliance or noncompliance. The commenter suggested that the rule should incorporate a provision concerning judicial review. It is beyond the Agency's jurisdiction to specify the availability or scope of judicial review of agency actions. That issue is for the courts to decide.

The commenter requested the addition of a provision whereby the Agency would award attorneys fees to complainants and requested the addition of a provision whereby compensation would be awarded to the prevailing parties in administrative proceedings. There is no general authorization in title V of the Rehabilitation Act for the Agency award of attorney fees in Agency administrative proceedings, or for the payment of compensation to prevailing parties in Agency proceedings. For this reason the Agency has not adopted either an attorneys fee provision or a compensation provision in the final regulation.

Paragraph (l) permits the Agency to delegate its authority for investigating complaints to other Federal agencies. However, the statutory obligation of the Agency to make a final determination of compliance or noncompliance may not be delegated.

List of Subjects in 32 CFR Part 1906

Blind, Buildings, Civil rights, Equal employment opportunity, Federal buildings and facilities, Government employees, Handicapped.

Robert M. Gates,
Director of Central Intelligence.

(Catalog of Federal Domestic Assistance Numbers does not apply.)

The Agency amends title 32 of the Code of Federal Regulations, chapter XIX, by adding a new part 1906 to read as follows:

PART 1906—ENFORCEMENT OF NONDISCRIMINATION ON THE BASIS OF HANDICAP IN PROGRAMS OR ACTIVITIES CONDUCTED BY THE CENTRAL INTELLIGENCE AGENCY

Sec.

- 1906.101 Purpose.
- 1906.102 Application.
- 1906.103 Definitions.
- 1906.104–1906.109 [Reserved]
- 1906.110 Self-evaluation.
- 1906.111 Notice.
- 1906.112–1906.129 [Reserved]
- 1906.130 General prohibitions against discrimination.
- 1906.131–1906.139 [Reserved]
- 1906.140 Employment.
- 1906.141–1906.148 [Reserved]
- 1906.149 Program accessibility: Discrimination prohibited.
- 1906.150 Program accessibility: Existing facilities.
- 1906.151 Program accessibility: New construction and alterations.
- 1906.152–1906.159 [Reserved]
- 1906.160 Communications.
- 1906.161–1906.169 [Reserved]
- 1906.170 Compliance procedures.

Authority: 19 U.S.C. 794.

§ 1906.101 Purpose.

The purpose of this part is to effectuate section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which amended section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of handicap in programs or activities conducted by Executive agencies or the United States Postal Service.

§ 1906.102 Application.

This part applies to all programs or activities conducted by the Agency except for programs or activities conducted outside the United States that do not involve handicapped persons in the United States. This regulation will apply to the Agency only to the extent consistent with the National Security Act of 1947 (50 U.S.C. 402 *et seq.*), as amended; the Central Intelligence Agency Act of 1949 (50 U.S.C. 403a *et*

seq.), as amended; and other applicable law.

§ 1906.103 Definitions.

For purposes of this part, the following terms means—

Assistant Attorney General means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

Auxiliary aids means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the Agency. For example, auxiliary aids useful for persons with impaired vision include readers, materials in braille, audio recordings, and other similar services and devices. Auxiliary aids useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices. The Central Intelligence Agency may prohibit from any of its facilities any auxiliary aid, or category of auxiliary aid, that the Office of Security (OS) determines creates a security risk or potential security risk. OS reserves the right to examine any auxiliary aid brought into an Agency facility.

Complete complaint means a written statement that contains the complainant's name and address and describes the Agency's alleged discriminatory action in sufficient detail to inform the Agency of the nature and date of the alleged violation of section 504. It must be signed by the complainant or by someone authorized to do so on his or her behalf. Complaints filed on behalf of classes or third parties must describe or identify (by name, if possible) the alleged victims of discrimination.

Director means the Director of Central Intelligence or an official or employee of the Agency acting for the Director under a delegation of authority.

Facility means all or any portion of buildings, structures, equipment, roads, walks, parking lots, rolling stock or other conveyances or other real or personal property.

Individual with handicaps means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. As used in this definition, the phrase—

(1) *Physical or mental impairment* includes—

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Cardiovascular; Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or

(ii) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

(2) *Major life activities* includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working;

(3) *Has a record of such an impairment* means has a history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more major life activities.

(4) *Is regarded as having an impairment* means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but is treated by the Agency as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward the impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by the Agency as having such an impairment.

Qualified individual with handicaps means—

(1) With respect to any Agency program or activity under which a person is required to perform services or to achieve a level of accomplishment, an individual with handicaps who meets the essential eligibility requirements and who can achieve the purpose of the program or activity without modifications in the program or activity that the Agency can demonstrate would result in a fundamental alteration in its nature;

(2) With respect to any other Agency program or activity, an individual with handicaps who meets the essential eligibility requirements for participation

in, or receipt of benefits from, that program or activity; and

(3) "Qualified handicapped person" as that term is defined for purposes of employment in 29 CFR 1613.702(f), which is made applicable to this part by § 1906.140.

Section 504 means section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112, 87 Stat. 394 (29 U.S.C. 794)), as amended by the Rehabilitation Act Amendments of 1974 (Pub. L. 93-516, 88 Stat. 1617); the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95-002, 92 Stat. 2955); and the Rehabilitation Act Amendments of 1986 (Pub. L. 99-506, 100 Stat. 1810). As used in this part, section 504 applies only to programs or activities conducted by the Agency and not to federally assisted programs.

§ 1906.104-1906.109 [Reserved]

§ 1906.110 Self-evaluation.

(a) The Agency shall, within one year of the effective date of this part, evaluate its current policies and practices, and the effect thereof, that do not or may not meet the requirements of this part, and to the extent modification of any of those policies and practices is required, the Agency shall proceed to make the necessary modifications.

(b) The Agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps to participate in the self-evaluation process by submitting comments (both oral and written).

(c) The Agency shall, for at least 3 years following completion of the self-evaluation, maintain on file, and make available for public inspection—

(1) A description of areas examined and any problems identified; and

(2) A description of any modifications made.

§ 1906.111 Notice.

The Agency shall make available, to employees, applicants, participants, beneficiaries, and other interested persons, such information regarding the provisions of this part and its applicability to the programs or activities conducted by the Agency, and make that information available to them in such manner as the Director finds necessary to apprise those persons of the protections against discrimination assured them by section 504 and the regulations in this part.

§§ 1906.112-1906.129 [Reserved]

§ 1906.130 General prohibitions against discrimination.

(a) No qualified individual with handicaps shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under, any program or activity conducted by the Agency.

(b)(1) The Agency, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified individual with handicap the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Deny a qualified individual with handicaps an opportunity to obtain the same result, to gain the same benefit, to reach the same level of achievement as that provided to others;

(iii) Provide a qualified individual with handicaps with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aid, benefits, or services to individuals with handicaps or to any class of individuals with handicaps than is provided to others unless that action is necessary to provide qualified individuals with handicaps with aid, benefits, or services that are as effective as those provided to others;

(v) Deny a qualified individual with handicaps the opportunity to participate as a member of planning or advisory boards; or

(vi) Otherwise limit a qualified individual with handicaps in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) The Agency may not deny a qualified individual with handicaps the opportunity to participate in programs or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) The Agency may not, directly or through contractual or other arrangements, utilize criteria or methods of administration the purpose or effect of which would—

(i) Subject qualified individuals with handicaps to discrimination on the basis of handicap; or

(ii) Defeat or substantially impair accomplishment of the objectives of a

program or activity with respect to individuals with handicaps.

(4) The Agency may not, in determining the site or location of a facility, make selections the purpose or effect of which would—

(i) Exclude individuals with handicaps from, deny them the benefits of, or otherwise subject them to discrimination under, any program or activity conducted by the Agency; or

(ii) Defeat or substantially impair the accomplishment of the objectives of a program or activity with respect to individuals with handicaps.

(5) The Agency, in the selection of procurement contractors, may not use criteria that subject qualified individuals with handicaps to discrimination on the basis of handicap.

(6) The Agency may not administer a licensing or certification program in a manner that subjects qualified individuals with handicaps to discrimination on the basis of handicap, nor may the Agency establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with handicaps to discrimination on the basis of handicap. However, the programs or activities of entities that are licensed or certified by the Agency are not, themselves, covered by this part.

(c) The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or Executive Order to individuals with handicaps or the exclusion of a specific class of individuals with handicaps from a program limited by Federal statute or Executive Order to a different class of individuals with handicaps is not prohibited by this part.

(d) The Agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps.

§§ 1906.131–1906.139 [Reserved]

§ 1906.140 Employment.

No qualified individual with handicaps shall, solely on the basis of handicap, be subjected to discrimination in employment under any program or activity conducted by the Agency. The definitions, requirements, and procedures of section 501 of the Rehabilitation Act of 1979 (29 U.S.C. 791), as established by the Equal Employment Opportunity Commission in 29 CFR part 1613, shall apply to employment in federally conducted programs or activities.

§§ 1906.141–1906.148 [Reserved]

§ 1906.149 Program accessibility: Discrimination prohibited.

Except as otherwise provided in § 1906.150, no qualified individual with handicaps shall, because the Agency's facilities are inaccessible to or unusable by individuals with handicaps, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity conducted by the Agency.

§ 1906.150 Program accessibility: Existing facilities.

(a) General. The Agency shall operate each program or activity so that the program or activity, viewed in its entirety, is readily accessible to and usable by individuals with handicaps. This program does not—

(1) Necessarily require the Agency to make each of its existing facilities accessible to and usable by individuals with handicaps;

(2)(i) Require the Agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens.

(ii) The Agency has the burden of proving that compliance with § 1906.150(a) would result in that alteration or those burdens.

(iii) The decision that compliance would result in that alteration or those burdens must be made by the Director after considering all of the Agency's resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion.

(iv) If an action would result in that alteration or those burdens, the Agency shall take any other action that would not result in the alteration or burdens but would nevertheless ensure that individuals with handicaps receive the benefits and services of the program or activity.

(b) Methods. (1) The Agency may comply with the requirements of this section through such means as redesign of equipment, reassignment of services to accessible buildings, assignment of aides to beneficiaries, home visits, delivery of services at alternate accessible sites, alteration of existing facilities and construction of new facilities, use of accessible rolling stock, or any other methods that result in making its programs or activities readily accessible to and usable by individuals with handicaps.

(2) The Agency is not required to make structural changes in existing facilities if other methods are effective in achieving compliance with this section.

(3) The Agency, in making alterations to existing buildings, shall meet accessibility requirements to the extent compelled by the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), and any regulations implementing that Act.

(4) In choosing among available methods for meeting the requirements of this section, the Agency shall give priority to those methods that offer programs and activities to qualified individuals with handicaps in the most integrated setting appropriate.

(c) Time period for compliance. The Agency shall comply with the obligations established under this section within 60 days of the effective date of this part except that if structural changes in facilities are undertaken, the changes shall be made within 3 years of the effective date of this part, but in any event as expeditiously as possible.

(d) Transition plan. (1) In the event that structural changes to facilities will be undertaken to achieve program accessibility, the Agency shall develop, within 6 months of the effective date of this part, a transition plan setting forth the steps necessary to complete those changes.

(2) The Agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the development of the transition plan by submitting comments (both oral and written). A copy of the transition plan must be made available for public inspection.

(3) The plan must, at a minimum—

(i) Identify physical obstacles in the Agency's facilities that limit the accessibility of its programs or activities to individuals with handicaps;

(ii) Describe in detail the methods that will be used to make the facilities accessible;

(iii) Specify the schedule for taking the steps necessary to achieve compliance with this section and, if the time period of the transition plan is longer than one year, identify steps that will be taken during each year of the transition period; and

(iv) Indicate the official responsible for implementation of the plan.

1906.151 Program accessibility: New construction and alterations.

Each building or part of a building that is constructed or altered by, on

behalf of, or for the use of, the Agency shall be designed, constructed, or altered so as to be readily accessible to and usable by individuals with handicaps. The definitions, requirements, and standards of the Architectural Barriers Act of 1968 (42 U.S.C. 4151-4175), as established in 41 CFR 101-19.600 to 101-19-607, apply to buildings covered by this section.

§§ 1906.152-1906.159 [Reserved]

§ 1906.160 Communications.

(a) The Agency shall take appropriate steps to ensure effective communication with applicants, participants, personnel of other Federal entities, and members of the public as follows:

(1)(i) The Agency shall furnish appropriate auxiliary aids if necessary to afford an individual with handicaps an equal opportunity to participate in, and enjoy the benefits of, a program or activity conducted by the Agency.

(ii) In determining what type of auxiliary aid is necessary, the Agency shall give primary consideration to the requests of the individual with handicaps.

(2) Where the Agency communicates with applicants and beneficiaries by telephone, telecommunication devices for deaf persons (TDD's) or equally effective telecommunication systems shall be used to communicate with persons with impaired hearing.

(b) The Agency shall ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of accessible services, activities, and facilities.

(c) The Agency shall provide signage at a primary entrance to each of its inaccessible facilities, directing users to a location at which they can obtain information about accessible facilities. The international symbol for accessibility shall be used at each primary entrance of an accessible facility.

(d) This section does not require the Agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens. In those circumstances where Agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the Agency has the burden of proving that compliance with § 1906.160 would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the Agency head or his or her

designee after considering all Agency resources available for use in the funding and operation of the conducted program or activity and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action required to comply with this section would result in such an alteration or such burdens, the Agency shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with handicaps receive the benefits and services of the program or activity.

§§ 1906.161-1906.169 [Reserved]

§ 1906.170 Compliance procedures.

(a) Except as provided in paragraph (b) of this section, this section applies to all allegations of discrimination on the basis of handicap in programs and activities conducted by the Agency.

(b) The Agency shall process complaints alleging violations of section 504 with respect to employment according to the procedures established by the Equal Employment Opportunity Commission in 29 CFR part 1613 pursuant to section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791).

(c) The Director, Office of Equal Employment Opportunity, is responsible for coordinating implementation of this section. Complaints may be sent to Central Intelligence Agency, Director, Office of Equal Employment Opportunity, Washington, DC 20505.

(d) The Agency shall accept and investigate all complete complaints for which it has jurisdiction. All complete complaints must be filed within 180 days of the alleged act of discrimination. The Agency may extend this time period for good cause.

(e) If the Agency receives a complaint over which it does not have jurisdiction, it shall promptly notify the complainant and shall make reasonable efforts to refer the complaint to the appropriate government entity.

(f) The Agency shall notify the Architectural and Transportation Barriers Compliance Board upon receipt of any complaint alleging that a building or facility that is subject to the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151-4157) is not readily accessible to and usable by individuals with handicaps.

(g) Within 180 days of the receipt of a complete complaint for which it has jurisdiction, the Agency shall notify the complainant of the results of the investigation in a letter containing—

(1) Findings of fact and conclusions of law;

(2) A description of a remedy for each violation found; and

(3) A notice of the right to appeal.

(h) Appeals of the findings of fact and conclusions of law or remedies must be filed by the complainant within 90 days of receipt from the Agency of the letter required by § 1906.170(g). The Agency may extend this time for good cause.

(i) Timely appeals shall be accepted and processed by the Director.

(j) The Agency shall notify the complainant of the results of the appeal within 60 days of the receipt of the request. If the Agency determines that it needs additional information from the complainant, it shall have 60 days from the date it receives the additional information to make its determination on the appeal.

(k) The time limits cited in paragraphs (g) and (j) of this section may be extended with the permission of the Assistant Attorney General.

(l) The Director may delegate the authority for conducting complaint investigations to other Federal agencies, except that the authority for making the final determination may not be delegated.

[FR Doc. 92-20972 Filed 8-31-92; 8:45 am]

BILLING CODE 6310-02-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 3

[CGD 92-046]

Realignment of Marine Inspection Zones and Captain of the Port Zones for New Orleans, and Morgan City, LA, and Port Arthur, TX

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: This temporary rule realigns the Marine Inspection and Captain of the Port Zones for the Coast Guard Marine Safety Offices in New Orleans and Morgan City, Louisiana, and Port Arthur, Texas. These changes are being made due to the damage resulting from Hurricane Andrew in the Morgan City, Louisiana, area and are expected to remain in effect for approximately two weeks or until effective command and control is reestablished in Morgan City.

EFFECTIVE DATE: This rule is effective from August 28, 1992 until September 30, 1992.

FOR FURTHER INFORMATION CONTACT:

Commander David W. Jones, Project Manager, Office of Marine Safety, Security, and Environmental Protection (G-MPS-3), (202) 267-0491, between 7 a.m. and 3:30 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:**Drafting Information**

The principal persons involved in drafting this document are Commander David W. Jones, Project Manager, Office of Marine Safety, Security, and Environmental Protection, and Ms. Christena G. Green, Project Counsel, Office of Chief Counsel.

Discussion of Rule

The boundaries of the Marine Inspection Zones and Captain of the Port Zones for Coast Guard Marine Safety Offices, New Orleans and Morgan City, Louisiana and Port Arthur, Texas, are being temporarily adjusted due to the damage suffered in the Morgan City, Louisiana area as a result of Hurricane Andrew. This adjustment will not impair any services by the Coast Guard to the public.

No notice of proposed rulemaking was prepared for this final rule, which covers "agency organization" and is therefore exempt from the requirements of 5 U.S.C. 553(b) for notice and comment. Since the rule has no substantive effect, good cause exists under 5 U.S.C. 553(d) to give it effect less than 30 days after publication. It temporarily realigns three Marine Inspection and Captain of the Port Zones due to the damage suffered in the Morgan City, Louisiana area as a result of Hurricane Andrew. Functions previously performed by the Coast Guard Marine Safety Office in Morgan City, Louisiana will be temporarily assumed by the Coast Guard Marine Safety Offices in New Orleans, Louisiana, and Port Arthur, Texas.

Regulatory Evaluation

This final rule is exempt from the provisions of Executive Order 12291 because it pertains to matters of "agency organization" as provided for in section 1(a)(3) of the Order. It is "nonsignificant" under DOT regulatory policies and procedures (44 FR 11040; February 26, 1979). Its economic impact has been found to be so minimal that further evaluation is unnecessary. It places no new requirements on any sector of the public. It will ensure uninterrupted services by the Coast Guard to the public. As its impact is minimal, the Coast Guard certifies that it will not have a significant economic impact on a substantial number of small entities.

Collection of Information

This final rule contains no collection-of-information requirements under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

Federalism

The Coast Guard has analyzed this final rule in accordance with the principles and criteria contained in Executive Order 12612 and has determined that the rule does not have sufficient implications for federalism to warrant the preparation of a Federalism Assessment. This temporary organizational realignment has no preemptive effect.

Environment

The Coast Guard considered the environmental impact of this final rule and concluded that, under section 2.B.2 of Commandant Instruction M16475.1B, the rule is categorically excluded from further environmental documentation. The rule is an administrative matter within the meaning of subsection 2.B.2.1 of Commandant Instruction M16475.1B that clearly has no environmental impact.

List of Subjects in 33 CFR Part 3

Organization and functions (Government agencies).

For the reasons set out in the preamble, the Coast Guard temporarily amends 33 CFR part 3 as follows:

PART 3—COAST GUARD AREAS, DISTRICTS, MARINE INSPECTION ZONES, AND CAPTAIN OF THE PORT ZONES

1. The authority citation for part 3 continues to read as follows:

Authority: 14 U.S.C. 633; 49 CFR 1.45, 1.46.

2. Section 3.40-15 is amended by temporarily adding a new paragraph (c) to read as follows:

§ 3.40-15 New Orleans Marine Inspection Zone and Captain of the Port Zone.

(c) The New Orleans Marine Inspection Zone and Captain of the Port Zone also includes that portion east of 91°30' W. longitude of the area which starts at 28°50' N. latitude, 88°00' W. longitude; thence due west to 28°50' N. latitude, 89°27'06" W. longitude; thence northwesterly to 29°18' N. latitude, 90°00' W. longitude; thence northwesterly along the northern boundaries of Lafourche, Assumption, Iberia, and St. Martin parishes; thence westerly along the westerly boundary of Lafayette Parish; thence northwesterly along the northern boundary of Acadia

Parish; to an intersection with 92°23' W. longitude; thence south along 92°23' W. longitude to the sea, with the exception that the New Orleans Captain of the Port Zone does not include the area described in § 3.40-17(b).

3. Section 3.40-17 is amended by temporarily revising paragraph (b) to read as follows:

§ 3.40-17 Morgan City Marine Inspection Zone and Captain of the Port Zone.

(b) The Morgan City Captain of the Port zone is composed of the following segments of waterways: the Intracoastal Waterway Morgan City to Port Allen Alternate Route from Mile 0 to Mile 5; the Intracoastal Waterway from Mile 93 West of Harvey Lock (WHL) to Mile 99 WHL; the Atchafalaya River Route from Mile 113 to Mile 122; from Bayou Boeuf (Intracoastal Waterway Mile 94.5 WHL) south one statute mile along Bayou Shaffer; and from Berwick Lock northwest one statute mile along the Lower Atchafalaya River.

4. Section 3.40-20 is amended by temporarily adding a new paragraph (c) to read as follows:

§ 3.40-20 Port Arthur Marine Inspection Zone and Captain of the Port Zone.

(c) The Port Arthur Marine Inspection Zone and Captain of the Port Zone also includes that portion west of 91°30' W. longitude of the area which starts at 28°50' N. latitude, 88°00' W. longitude; thence due west to 28°50' N. latitude, 89°27'06" W. longitude; thence northwesterly to 29°18' N. latitude, 90°00' W. longitude; thence northwesterly along the northern boundaries of Lafourche, Assumption, Iberia, and St. Martin parishes; thence westerly along the westerly boundary of Lafayette Parish; thence northwesterly along the northern boundary of Acadia Parish; to an intersection with 92°23' W. longitude; thence south along 92°23' W. longitude to the sea.

Dated: August 28, 1992.

A.E. Henn,

Rear Admiral, U.S. Coast Guard Chief, Office of Marine Safety, Security and Environmental Protection.

[FR Doc. 92-21130 Filed 8-28-92; 1:52 pm]

BILLING CODE 4910-14-M

33 CFR Part 117

[CGD8-92-23]

Drawbridge Operation Regulations; Choctawhatchee River, Florida

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: This document removes the regulation for the State Route 20 swing span bridge across the Choctawhatchee River, mile 20.0, at Ebro, Florida, because a fixed span replacement bridge has been constructed and the swing span bridge has been removed. Notice and public procedure have been omitted from this action since the swing span bridge is no longer in existence.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Mr. John Wachter, Bridge Administration Branch, Eighth Coast Guard District, telephone (504) 589-2965.

SUPPLEMENTARY INFORMATION: This action has no economic consequences. It merely removes a regulation that is now meaningless because it pertains to a drawspan that no longer exists. Consequently, this action is considered to be non-major under Executive Order 12291 and nonsignificant under Department of Transportation regulatory policies and procedures (44 FR 11034, February 26, 1979). Since there is no economic impact, a full regulatory rulemaking is required under 5 U.S.C. 553, this action is exempt from the Regulatory Flexibility Act (5 U.S.C. 605(b)). However, this action will not have a significant economic impact on a substantial number of small entities.

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that this action does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Drafting Information

The drafters of this document are Mr. John Wachter, project officer, and LT J.A. Wilson, project attorney.

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

In consideration of the foregoing, part 117 of title 33, Code of Federal Regulations, is amended as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05-1(g).

2. Section 117.275 is removed.

Dated: August 11, 1992.

J.C. Card,

Rear Admiral, U.S. Coast Guard, Commander,
Eighth Coast Guard District.

[FR Doc. 92-21011 Filed 8-31-92; 8:45 am]

BILLING CODE 4910-14-M

LIBRARY OF CONGRESS**Copyright Office****37 CFR Part 202**

[Docket No. 92-4]

**Registration of Claims to Copyright;
Group Registration of Daily
Newspapers**

AGENCY: Copyright Office, Library of Congress.

ACTION: Final regulations.

SUMMARY: The Copyright Office of the Library of Congress is adopting a new regulation that permits group registration of daily newspapers. Publishers of newspapers taking advantage of the new procedure will be allowed to register all issues of a given title published with issue dates in one calendar month on the basis of one application, a deposit of microfilm of the registered issues, and a fee of \$40. The amendments implement a portion of the Copyright Act of 1976, relating to the deposit requirements for copyright registration.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Dorothy Schrader, General Counsel, U.S. Copyright Office, Library of Congress, Washington, DC 20559. Telephone (202) 707-8380.

SUPPLEMENTARY INFORMATION: Under the Copyright Act of 1976, 17 U.S.C. 407, the owner of copyright, or of the exclusive right of publication, in a work published in the United States is required to deposit two copies of the work in the Copyright Office for the use or disposition of the Library of Congress. The deposit is to be made within three months after such publication. Failure to make the required deposit does not affect the copyright in the work, but may subject the copyright owner to fines and other monetary liability if the failure is continued after a demand for deposit is made by the Register of Copyrights.

Section 408 of title 17 of the United States Code requires deposit of material in connection with applications for registration of claims to copyright in unpublished and published works. Subsection 408(c)(1) of title 17 of the United States Code authorizes the Register of Copyrights to establish by regulation the nature of the deposit that

is required. These regulations may require or permit "a single registration for a group of related works."

In 1990, the Copyright Office implemented special procedures for group registrations of serials at 37 CFR 202.3(b)(5) (55 FR 50556). The new procedure covered weekly and monthly serials published within a three-month period. Serials published on a daily basis were not covered.

Shortly after the new procedure was implemented, the Newspaper Association of America approached the Copyright Office and the Library about establishing a group registration privilege for daily newspapers. Because of the expense of registering individual issues, currently most daily newspapers are not registered in the Copyright Office. While the lack of registration does not invalidate copyright, it does limit the availability of certain remedies should infringement occur.

The Library of Congress studied carefully the advantages of group registration from the standpoint of securing acquisitions to the collections. Currently, the Library purchases microfilm copies of selected daily newspapers. If these microfilm copies can be secured on a timely basis through copyright deposit, a substantial cost savings will accrue to the Library.

With these considerations in mind, the Copyright Office is implementing group registration procedures for daily newspapers on the basis of a single application, fee, and microfilm deposit. The regulations and the new procedures will be applied prospectively only to the issues of newspapers first published on or after the effective date. New form GDN will be used to cover issues of the same newspaper title published with issue dates in one calendar month. The dates of publication space on the form must specify the first and last issue dates of the works covered by the group registration application.

The deposit must consist of positive, 35mm silver halide microfilm meeting the Library's best edition criteria that reproduces in their entirety all issues published as final editions with issue dates in the designated calendar month. While the final edition of the daily newspapers must be included in the microfilm deposit, the claim to copyright and the deposit may also include earlier editions published the same day in a given metropolitan area served by the newspaper. The privilege of including these earlier editions does not apply, however, in the case of national or regional distribution beyond a given metropolitan area. Registration must be

sought within three months from the date of publication of the last issue included in the group registration application.

The fee for the registration service is a nonrefundable filing fee of \$40, which is the approximate cost of providing the service.

The regulation is issued without inviting public comment for these reasons: The regulation confers a positive benefit on the public affected; the regulation establishes an optional procedure only; and the Copyright Office prepared the regulation based on its experience in administering group registration of serials.

With respect to the Regulatory Flexibility Act, the Copyright Office takes the position that this Act does not apply to Copyright Office rulemaking. The Copyright Office is a department of the Library of Congress and is a part of the legislative branch. Neither the Library of Congress nor the Copyright Office is an "agency" within the meaning of the Administrative Procedure Act of June 11, 1946, as amended (5 U.S.C. 551 et seq. and 5 U.S.C. 701 et seq.) The Regulatory Flexibility Act consequently does not apply to the Copyright Office since that Act affects only those entities of the Federal Government that are agencies as defined in the Administrative Procedure Act.¹

Alternatively, if it is later determined by a court of competent jurisdiction that the Copyright Office is an "agency" subject to the Regulatory Flexibility Act, the Register of Copyrights has determined and hereby certifies that this regulation will have no significant impact on small business.

List of Subjects in 37 CFR Part 202

Claims, Copyright, Newspapers and Magazines.

Final Regulations

In consideration of the foregoing, the Copyright Office is amending part 202 of 37 CFR, chapter II in the manner set forth below.

¹The Copyright Office was not subject to the Administrative Procedure Act before 1978, and it is now subject to it only in areas specified by section 701(d) of the Copyright Act (i.e., "all actions taken by the Register of Copyrights under this title (17), except with respect to the making of copies of copyright deposits"). (17 U.S.C. 706(b)). The Copyright Act does not make the Office an "agency" as defined in the Administrative Procedure Act. For example, personnel actions taken by the Office are not subject to APA-FOIA requirements.

PART 202 - [AMENDED]

1. The authority citation for part 202 continues to read as follows:

Authority: Section 702, 90 Stat. 2541, 17 U.S.C. 702; 202.3 is also issued under 17 U.S.C. 407 and 408.

§ 202.3 [Amended]

2. In § 202.3 paragraphs (b)(6) and (7) are redesignated as paragraphs (b)(7) and (8) respectively.

3. Section 202.3(b)(6) is added to read as follows:

§ 202.3 Registration of copyright.

* * * * *

(b) * * *

(6) *Group registration of daily newspapers.* (i) Pursuant to the authority granted by 17 U.S.C. 408(c)(1), the Register of Copyrights has determined that, on the basis of a single application, microfilm deposit, and filing fee, a single registration may be made for a group of daily newspapers published in a microfilm format if the following conditions are met:

(A) Registration covers a full month of issues of the same newspaper title published with issue dates in one calendar month.

(B) A completed GDN application form is submitted.

(C) A publication date is specified designating the first and last day that issues in the group were published.

(D) A deposit is made of positive, 35mm silver halide microfilm meeting the Library's best edition criteria that includes all issues published as final editions in the designated calendar month. In addition to the final edition of the daily newspaper, the claim to copyright and the deposit may also include earlier editions published the same day in a given metropolitan area served by the newspaper, but may not include national or regional editions distributed beyond a given metropolitan area.

(E) A nonrefundable filing fee of \$40 is included with the submission, or charged to an active deposit account.

(F) Registration is sought within three months after the publication date of the last issue included in the group.

(ii) As used in this regulation, newspapers means serials which are classified as newspapers under the policy document "Newspapers Received Currently in the Library of Congress," which is administered by the Newspaper Section of the Serials & Government Publications Division of the

Library of Congress. In general, serials classified as newspapers are serials mainly designed to be a primary source of written information on current events, either local, national, or international in scope. A newspaper contains a broad range of news on all subjects and activities and is not limited to any specific subject matter. Newspapers are intended either for the general public or for a particular ethnic, cultural, or national group.

* * * * *

Dated: August 5, 1992.

Ralph Oman,
Register of Copyrights.

Approved by:
James H. Billington,
The Librarian of Congress.

[FR Doc. 92-20947 Filed 8-31-92; 6:45 am]

Billing Code 1410-07-F

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 6943

[NM-930-4214-10; NMNM 83404]

Withdrawal of Public Lands for Highly Significant Caves and Their Associated Resources; New Mexico

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order withdraws 2,924.65 acres of public lands from surface entry and mining, and 440 acres of federally reserved mineral interests underlying private surface estate from mining for a period of 20 years for the Bureau of Land Management to protect highly significant caves and their associated resources in Eddy County. The lands have been and remain open to mineral leasing.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Georgiana E. Armijo, BLM New Mexico State Office, P.O. Box 27115, Santa Fe, New Mexico 87502, 505-438-7594.

By virtue of the authority vested in the Secretary of the Interior by section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. Subject to valid existing rights, the following described public lands are hereby withdrawn from settlement, sale, location, or entry under the general land laws, including the United States mining laws (30 U.S.C. ch. 2 (1988)), but not from leasing under the mineral leasing

laws, to protect highly significant caves and their associated resources:

New Mexico Principal Meridian

McKittrick Hill Caves

- T. 22 S., R. 24 E.,
 sec. 14, S½SW¼, SW¼SE¼, and W¼SE¼SE¼;
 sec. 22, S½SW¼NE¼, SE¼NE¼, SE¼SE¼NW¼, E½E½SW¼, and SE¼;
 sec. 23, W¼, W½E½, and W½E½E½;
 sec. 26, W½NE¼NE¼, NW¼NE¼, and N½NW¼;
 sec. 27, N½NE¼ and E½NE¼NW¼.

Mudgetts/Little Mudgetts Caves

- T. 24 S., R. 24 E.,
 sec. 21, SE¼SW¼NW¼, SW¼SE¼NW¼, N½NE¼SW¼, and NE¼NW¼SW¼.

Big Manhole/Little Manhole Caves

- T. 24 S., R. 24 E.,
 sec. 22, W½NE¼SW¼, E½SW¼SW¼, SE¼SW¼, and W½SW¼SE¼.

Honest Injun Cave

- T. 22 S., R. 25 E.,
 sec. 28, lot 6.

Yellow Jacket and Lair Caves

- T. 23 S., R. 25 E.,
 sec. 14, S½SE¼SW¼ and S½S½SE¼;
 sec. 23, NE¼ and NE¼NW¼.

KFF (Elliott's) Cave

- T. 24 S., R. 25 E.,
 sec. 23, SE¼NE¼SE¼ and E½SE¼SE¼;
 sec. 24, W½NE¼SW¼, NW¼SW¼, N½SW¼SW¼, SW¼SW¼SW¼, and NW¼SE¼SW¼.

Chosa Draw Caves

- T. 25 S., R. 25 E.,
 sec. 20, E½SE¼;
 sec. 21, S½SE¼NE¼ and S½;
 sec. 22, SW¼SW¼NW¼ and W½W½SW¼;
 sec. 27, W½NW¼NW¼;
 sec. 28, E½NE¼;
 sec. 29, E½NE¼, E½W½NE¼, NE¼SE¼, and E½NW¼SE¼.

Lost Cave

- T. 22 S., R. 26 E.,
 sec. 22, NE¼NE¼NE¼ and N½SE¼NE¼NE¼;
 sec. 23, W½NW¼NW¼NW¼ and NW¼SW¼NW¼NW¼.

Fence Canyon Cave Area

- T. 24 S., R. 26 E.,
 sec. 17, NW¼NW¼;
 sec. 18, lot 3, E½NE¼NE¼, S½NE¼, SE¼NW¼, NE¼SW¼, N½SE¼SW¼, and N½SE¼.

The areas described aggregate approximately 2,924.64 acres in Eddy County.

2. Subject to valid existing rights, the federally reserved mineral interests in the following described land are hereby withdrawn from mining under the United States mining laws (30 U.S.C. Ch. 2 (1988)), but not from leasing under the mineral leasing laws, to protect highly

significant caves and their associated resources:

New Mexico Principal Meridian

Chosa Draw Caves

- T. 25 S., R. 25 E.,
 sec. 28, NW¼NE¼, W½, and W½SE¼.
 The area described contains 440 acres in Eddy County.

3. The withdrawal made by this order does not alter the applicability of those public land laws governing the use of the lands under lease, license, or permit, or governing the disposal of their mineral or vegetative resources other than under the mining laws.

4. This withdrawal will expire 20 years from the effective date of this order unless, as a result of a review conducted before the expiration date pursuant to section 204(f) of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714(f) (1988), the Secretary determines that the withdrawal shall be extended.

Dated: August 20, 1992.

Dave O'Neal,

Assistant Secretary of the Interior.

[FR Doc. 92-20955 Filed 8-31-92; 8:45 am]

BILLING CODE 4310-FB-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA-7545]

List of Communities Eligible for the Sale of Flood Insurance

AGENCY: Federal Insurance Administration, FEMA.

ACTION: Final rule.

SUMMARY: This rule identifies communities participating in the National Flood Insurance Program (NFIP). These communities have applied to the program and have agreed to enact certain floodplain management measures. The communities' participation in the program authorizes the sale of flood insurance to owners of property located in the communities listed.

EFFECTIVE DATES: The dates listed in the fourth column of the table.

ADDRESSES: Flood insurance policies for property located in the communities listed can be obtained from any licensed property insurance agent or broker serving the eligible community, or from the NFIP at: Post Office Box 457, Lanham, MD 20706, (800) 638-7418.

FOR FURTHER INFORMATION CONTACT: Frank H. Thomas, Assistant

Administrator, Office of Loss Reduction, Federal Insurance Administration, 500 C Street, SW., room 417, Washington, DC 20472, (202) 646-2717.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Since the communities on the attached list have recently entered the NFIP, subsidized flood insurance is now available for property in the community.

In addition, the Director of the Federal Emergency Management Agency has identified the special flood hazard areas in some of these communities by publishing a Flood Hazard Boundary Map (FHBM) or Flood Insurance Rate Map (FIRM). The date of the flood map, if one has been published, is indicated in the fifth column of the table. In the communities listed where a flood map has been published, section 102 of the Flood Disaster Protection Act of 1973, as amended, 42 U.S.C. 4012(a), requires the purchase of flood insurance as a condition of Federal or federally related financial assistance for acquisition or construction of buildings in the special flood hazard areas shown on the map.

The Director finds that the delayed effective dates would be contrary to the public interest. The Director also finds that notice and public procedure under 5 U.S.C. 553(b) are impracticable and unnecessary.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

This rule will not have a significant economic impact on a substantial number of small entities in accordance with the Regulatory Flexibility Act, 5 U.S.C. 601 et seq.

Regulatory Impact Analysis

This rule is not a major rule under Executive Order 11291, Federal Regulation, February 17, 1981, 3 CFR, 1981 Comp., p. 127.

No regulatory impact analysis has been prepared.

Paperwork Reduction Act

This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 et seq.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, October 26, 1987, 3 CFR, 1987 Comp., p. 252.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive

Order 12778, October 25, 1991, 56 FR 55195, 3 CFR, 1991 Comp., p. 309.

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.
Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

1. The authority citation for part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*, Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 64.6 [Amended]

2. The tables published under the authority of § 64.6 are amended as follows:

State and location	Community No.	Effective date of authorization/cancellation of sale of flood insurance in community	Current effective map date
New Eligibles—Emergency Program			
Georgia:			
Colquitt, city of, Miller County	130135	July 22, 1992	September 24, 1976.
Rocky Ford, town of, Screven County	130162	July 22, 1992	January 16, 1976.
New Hampshire:			
Mason, town of, Hillsborough County	330221	July 29, 1992	February 21, 1975.
Michigan:			
Nashville, village of, Barry County	260902	July 29, 1992	Do.
New Eligible—Regular Program			
Arizona:			
Quartzsite, town of, La Paz County	040134	June 21, 1983, emerg.; September 19, 1984, reg.	Do.
Texas:			
Rancho Viejo, town of, Cameron County	481646	July 10, 1992	Do.
Arizona:			
Queen Creek, town of, Maricopa County	040132	July 22, 1992	September 4, 1991.
Reinstatements—Regular Program			
Missouri:			
Piedmont, city of, Wayne County	290451	June 4, 1975, emerg.; September 30, 1988, reg.; March 5, 1990, susp.; July 21, 1992, rein.	September 30, 1988.
Tennessee:			
Lake County, unincorporated areas	470334	April 22, 1975, emerg.; March 16, 1981, reg.; March 16, 1981, susp.; June 22, 1992, rein.	March 16, 1981.
Farragut, town of, Knox County	470387	August 14, 1970, emerg.; July 23, 1971, reg.; February 17, 1988, susp.; June 23, 1992, rein.	February 15, 1985.
Pennsylvania:			
Longswamp, township of, Berks County	421380	November 24, 1975, emerg.; July 3, 1990, reg.; July 3, 1990, susp.; July 23, 1992, rein.	July 3, 1990.
Virginia:			
Prince George County, unincorporated areas	510204	May 17, 1974, emerg.; May 1, 1980, reg.; May 1, 1980, susp.; July 29, 1992, rein.	May 1, 1980.
Regular Program Conversions			
Region III			
West Virginia:			
Harrison County, unincorporated areas	540053	July 2, 1992, suspension withdrawn	July 2, 1992.
Marion County, unincorporated areas	540097	do	July 2, 1992.
Somerset, township of, Somerset County	422055	do	July 2, 1992.
Pennsylvania:			
Greene, township of, Pike County	421865	do	July 2, 1992.
Region VI			
Arkansas:			
Ward, city of, Lonoke County	050372	do	July 2, 1992.
Texas:			
Brazos County, unincorporated areas	481195	do	July 2, 1992.
Oklahoma:			
Lookeba, town of, Caddo County	400025	do	September 27, 1991.
Region I			
New Hampshire:			
Grantham, town of, Sullivan County	330158	July 15, 1992, suspension withdrawn	July 15, 1992.
South Hampton, town of, Rockingham County	330193	July 15, 1992, suspension withdrawn	July 15, 1992.
Region IV			
Florida:			
Manatee County, unincorporated areas	120153	do	July 15, 1992.
Region VIII			
Colorado:			
Fruita, town of, Mesa County	080194	do	July 15, 1992.
Grand Junction, city of, Mesa County	080117	do	July 15, 1992.

State and location	Community No.	Effective date of authorization/cancellation of sale of flood insurance in community	Current effective map date
Mesa County, unincorporated areas	080115	do.....	July 15, 1992.
Palisade, town of, Mesa County	080198	do.....	July 15, 1992.

¹ The Town of Quartzsite is a newly incorporated community that was participating in the regular program as an unincorporated area of La Paz County. The town has adopted the county's FIRM for floodplain management and insurance purposes.

Code for reading third column: Emerg.—Emergency; Reg.—Regular; Susp.—Suspension; Rein.—Reinstatement.

(Catalog of Federal Domestic Assistance No. 83.100, "Flood Insurance.")

Issued: August 21, 1992.

C.M. "Bud" Schauerle,
Administrator, Federal Insurance
Administration.

[FR Doc. 92-20994 Filed 8-31-92; 8:45 am]

BILLING CODE 6718-21-M

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Insurance
Administration, FEMA.

ACTION: Final rule.

SUMMARY: Base (100-year) flood elevations and modified base (100-year) flood elevations are made final for the communities listed below.

The base (100-year) flood elevations and modified base flood elevations are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

EFFECTIVE DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing base flood elevations and modified base flood elevations for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: William R. Locke, Chief, Risk Studies Division, Federal Insurance Administration, 500 C Street SW., Washington, DC 20472, (202) 646-2754.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA or Agency) gives notice of the final determinations of base flood elevations and modified base flood elevations for each community listed. The proposed base flood elevations and proposed modified base flood elevations were published in newspapers of local

circulation and an opportunity for the community or individuals to appeal the proposed determinations to or through the community was provided for a period of ninety (90) days. The proposed base flood elevations and proposed modified base flood elevations were also published in the Federal Register.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67.

The Agency has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

This rule will not have a significant economic impact on a substantial number of small entities in accordance with the Regulatory Flexibility Act, 5 U.S.C. 601 et seq.

Regulatory Impact Analysis

This rule is not a major rule under Executive Order 12291, February 17, 1981. No regulatory impact analysis has been prepared.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive Order 12778.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and Flood Insurance Rate Map available at the address cited below for each community.

The base flood elevations and modified base flood elevations are made final in the communities listed below. Elevations at selected locations in each community are shown.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read:

Authority: 42 U.S.C. 4001 et seq.; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19387, 3 CFR, 1979 Comp., p. 378.

§ 67.11 [Amended]

2. The tables published under the authority of § 67.11 are amended as follows:

PROPOSED BASE (100-YEAR) FLOOD ELEVATIONS

Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)
ARKANSAS	
Ouachita County (unincorporated areas) (FEMA docket No. 7042)	
<i>Two Bayou:</i>	
Approximately 1.3 miles downstream of Union Pacific Railroad	*113
At the downstream side of Old State Route 7	*114
<i>Ouachita River:</i>	
Approximately .5 mile downstream of State Route 45	*116
Approximately 0.85 mile upstream of U.S. Route 79	*117
Maps available for inspection at the Ouachita County Courthouse, 145 Jefferson Avenue, Camden, Arkansas.	
IOWA	
Davenport (City), Scott County (FEMA docket No. 7042)	
<i>Mississippi River:</i>	
About 2.4 miles downstream of Interstate 280	*563
About 1.8 miles upstream of U.S. Government Bridge	*568
<i>Black Hawk Creek:</i>	
At mouth	*564
About 450 feet downstream of Homestead Avenue	*566
Maps available for inspection at the City of Davenport, Division of Community and Economic Development, 226 West Fourth Street, Davenport, Iowa.	
Ely (city), Linn County (FEMA docket No. 7045)	
<i>Hoosier Creek:</i>	
About 0.3 mile downstream of Vista Road	*720
About 1.0 mile upstream of Vista Road	*731

PROPOSED BASE (100-YEAR) FLOOD ELEVATIONS—Continued		PROPOSED BASE (100-YEAR) FLOOD ELEVATIONS—Continued		PROPOSED BASE (100-YEAR) FLOOD ELEVATIONS—Continued	
Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)	Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)	Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)
Maps available for inspection at the City Hall, Community Center, 1570 Rowley Street, Ely, Iowa.		OKLAHOMA		TEXAS	
KANSAS		Lincoln County (unincorporated areas) (FEMA docket No. 7042)		Abilene (city), Taylor and Jones Counties (FEMA docket No. 7022)	
St. George (city), Pottawatomie County (FEMA docket No. 7042)		Belcow Creek:		Elm Creek:	
<i>Kansas River:</i>		Approximately 1.2 miles downstream of Burlington Northern Railroad.....		Approximately 1,700 feet upstream of U.S. Route 83 (lower crossing).....	
About 1,800 feet downstream of confluence of Blood Creek.....		Approximately .5 mile upstream of Lake Road.....		At U.S. Route 83.....	
About 650 feet upstream of confluence of Blackjack Creek.....		Belcow Creek Split:		Elm Creek Overflow Path 1:	
Maps available for inspection at the City Hall, St. George, Kansas.		At confluence with Belcow Creek.....		Approximately 800 feet upstream of the confluence with Elm Creek.....	
LOUISIANA		Approximately 0.45 mile upstream of Burlington Northern Railroad.....		At divergence from Elm Creek.....	
Ascension Parish (unincorporated areas) (FEMA docket No. 7034)		Indian Creek:		Elm Creek Overflow Path 2:	
<i>Bayou Francois:</i>		At confluence with Belcow Creek.....		Approximately 1,500 feet upstream of confluence with Elm Creek.....	
At confluence with New River.....		At downstream side of 8th Street.....		Approximately 1,500 feet downstream of divergence from Elm Creek Overflow Path 1.....	
Approximately 3.3 miles upstream of U.S. Route 61.....		Belcalf Creek:		Little Elm Creek:	
<i>Babin Canal:</i>		At confluence with Belcow Creek.....		At confluence with Elm Creek.....	
Approximately 350 feet downstream of Laurel Ridge Road.....		Approximately 300 feet downstream from Chandler Dam.....		Approximately .85 mile upstream of confluence with Elm Creek.....	
At George Lambert Road.....		Chuchaho Creek:		Swale A:	
<i>Henderson Bayou:</i>		Approximately 1.2 miles downstream of U.S. Route 66.....		Upstream side of Interstate Route 20.....	
At confluence with Amite River.....		Approximately 900 feet upstream of Section Road.....		Approximately 120 feet downstream of Vogel Avenue.....	
Approximately 150 feet upstream of State Route 933.....		North Canadian River: For entire length affecting community.....		Old Elm Creek Channel:	
<i>Muddy Creek:</i>		Maps available for inspection at the USDASCS Office, 710 Marvel Avenue, Chandler, Oklahoma.		Approximately 2,060 feet downstream of Interstate Route 20 culvert.....	
Confluence with Bayou Manchac.....		McClain County (unincorporated areas) (FEMA docket No. 7042)		At upstream side of Interstate Route 20 culvert.....	
Approximately 160 feet upstream of State Route 42.....		<i>Canadian River:</i>		Maps available for inspection at the City Hall, 555 Walnut, Abilene, Texas.	
<i>Black Bayou:</i>		At a point approximately .54 mile downstream of the confluence of Walnut Creek.....		Cove (town), Chambers County (FEMA docket No. 7042)	
At confluence of Babin Canal.....		At Interstate Route 35.....		<i>Hackberry Gully:</i>	
Approximately 0.5 mile downstream of State Highway 431.....		<i>Walnut Creek:</i>		At confluence with Cotton Bayou.....	
<i>New River:</i>		Approximately 875 feet upstream of the confluence with the Canadian River.....		Approximately 1,100 feet upstream of FM 565.....	
Approximately 150 feet downstream of confluence of Seveiro Canal.....		At a point approximately .76 mile upstream of Interstate Route 35.....		<i>Cotton Bayou:</i>	
Approximately 1.1 miles upstream of Seveiro Canal.....		<i>Beaver Creek:</i>		Approximately 0.5 mile downstream of FM 565.....	
<i>Amite River:</i>		At a point approximately 950 feet upstream of its confluence with Walnut Creek.....		Approximately 0.4 mile upstream of FM 565.....	
At confluence with Amite River Diversion Canal.....		At a point approximately 1,750 feet upstream of its confluence with Walnut Creek.....		<i>Trinity Bay:</i>	
At confluence of Bayou Manchac.....		<i>Crooked Bridge Creek:</i>		At Interstate Route 10.....	
Maps available for inspection at 42077 Church-point Road, Gonzales, Louisiana.		At a point approximately 1.1 miles upstream of State Route 74.....		Shoreline of Cotton Lake.....	
MISSOURI		At a point approximately 1.8 miles upstream of State Route 74.....		Maps available for inspection at the Chambers County Engineer's Office, 201 Airport Road, Anahuac, Texas.	
Ballwin (city), St. Louis County (FEMA docket No. 7045)		<i>Goldsby Creek:</i>		Lake Worth (city), Tarrant County (FEMA docket No. 7032)	
<i>Fishpot Creek:</i>		At Interstate Route 35.....		Lake Worth: Along the shoreline within the community.....	
Approximately 3,900 feet downstream of Reis Road.....		At a point approximately .38 mile upstream of Interstate Route 35.....		Maps available for inspection at the City Hall, 6720 Telephone Road, Lake Worth, Texas.	
Just downstream of Old Ballwin Road.....		<i>Stinson Creek:</i>		Old River-Winfree (town), Chambers County (FEMA docket No. 7042)	
Just upstream of Smith Drive.....		At a point approximately 4.2 miles upstream of its confluence with North Fork of Walnut Creek.....		<i>Backwater from the Trinity River:</i>	
Maps available for inspection at the City of Ballwin, 300 City Hall Drive, Ballwin, Missouri.		At a point approximately 4.3 miles upstream of its confluence with North Fork of Walnut Creek.....		<i>Caney Creek:</i> At FM 1409.....	
NEW YORK		Maps available for inspection at the McClain County Courthouse, 2nd and Washwestin, Purcell, Oklahoma.		<i>Old River:</i> In the vicinity of Woodland Lane.....	
Greenfield (town), Saratoga County (FEMA docket No. 7042)		Verden (town), Caddo and Grady Counties (FEMA docket No. 7042)		<i>The Cutoff:</i> 0.5 mile east of Hunters Cove.....	
<i>Kayaderoseras Creek:</i>		<i>Washita River:</i>		Maps available for inspection at the Chambers County Engineer's Office, 201 Airport Road, Anahuac, Texas 77514.	
Approximately 2 mile downstream of Galway Road.....		Approximately .6 mile downstream of Section Line Road.....		San Diego (city), Duval and Jim Wells Counties (FEMA docket No. 7042)	
Approximately 75 feet upstream of State Route 9N.....		Approximately 175 feet upstream of confluence of Line Creek.....		<i>San Diego Creek:</i>	
<i>South Branch:</i>		Maps available for inspection at the Verden Town Hall, 301 Morris, Verden, Oklahoma.		Approximately 450 feet downstream of Palacios Street.....	
At the confluence with Kayaderoseras Creek.....				Approximately 0.4 mile upstream of the Texas-Mexican Railroad.....	
Approximately 10 feet upstream of Allen Road.....				Maps available for inspection at the San Diego City Hall, 404 South Moir, San Diego, Texas.	
<i>Mud Creek:</i>				Westworth Village (city), Tarrant County (FEMA docket No. 7027)	
At the confluence with Kayaderoseras Creek.....				<i>Kings Branch:</i>	
Approximately 10 feet upstream of dam.....				At confluence with Farmers Branch.....	
Maps available for inspection at the Greenfield Town Hall, corner of Route 9N and Wilton Road, Greenfield Center, New York.					

PROPOSED BASE (100-YEAR) FLOOD
ELEVATIONS—Continued

Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)
Approximately 320 feet upstream of confluence Farmers Branch	*566
Approximately 2,050 feet upstream of confluence with West Fork Trinity River	*557
Approximately 620 feet downstream of State Route 341	*634
West Fork Trinity River on Carswell AFB: Approximately 480 feet upstream of confluence of Farmers Branch	*557
Approximately 2,000 feet upstream of confluence of Farmers Branch	*558
Maps available for inspection at the City Hall, 311 Burtonhill Road, Fort Worth, Texas.	

VERMONT

Stratford (town), Orange County (FEMA docket No. 7042)	
West Branch Ompompanoosuc River: Approximately 3,900 feet downstream of Town Highway 39	*824
Approximately 120 feet upstream of Town Highway 2	*1,000
Tunbridge Branch: At confluence with West Branch Ompompanoosuc River	*983
Approximately 1,850 feet upstream of confluence with West Branch Ompompanoosuc River	*1,027
Maps available for inspection at the Stratford Town Hall, Stratford, Vermont.	

WISCONSIN

Biron (Village), Wood County (FEMA docket No. 7042)	
Wisconsin River: About 1,800 feet upstream of Green Bay and Western Railroad	*1,014
Just downstream of Biron Dam	*1,022
Just upstream of Biron Dam	*1,035
About 3.0 miles upstream of Biron Dam	*1,037
Biron Overland Flow: At mouth	*1,021
Divergence with Wisconsin River	*1,037
Maps available for inspection at the Village Hall, Biron, Wisconsin.	
Nekoosa (City), Wood County (FEMA docket No. 7042)	
Wisconsin River: About 1.1 miles downstream of Nekoosa Dam	*937
Just downstream of Nekoosa Dam	*940
Just upstream of Nekoosa Dam	*950
About 1.3 feet upstream of State Highway 73	*954
Moccasin Creek: Within community	*955
Maps available for inspection at the City of Nekoosa, 225 1st Street, Nekoosa, Wisconsin.	

Port Edwards (Village), Wood County (FEMA docket No. 7042)	
Wisconsin River: About 1.3 miles upstream of State Highway 73	*954
Just downstream of Port Edwards Dam	*963
Just upstream of Port Edwards Dam	*968
Just downstream of Centralia Dam	*976
Just upstream of Centralia Dam	*984
About 2,150 feet upstream of Centralia Dam	*986
Moccasin Creek: Within community	*955
Nepco Lake: Along shoreline	*980
Maps available for inspection at the Village Hall, Port Edwards, Wisconsin.	

Wisconsin Rapids (City), Wood County (FEMA docket No. 7042)	
Wisconsin River:	

PROPOSED BASE (100-YEAR) FLOOD
ELEVATIONS—Continued

Source of flooding and location	#Depth in feet above ground. Elevation in feet (NGVD)
About 1,100 feet downstream of Centralia Dam	*975
Just downstream of Centralia Dam	*976
Just upstream of Centralia Dam	*984
Just downstream of Wisconsin Rapids Dam	*996
Just upstream of Wisconsin Rapids Dam	*1,011
About 1.3 miles downstream of Biron Dam	*1,019
Twomile Creek: Just upstream of Whitlock Avenue	*1,003
Just downstream of 8th Street	*1,008
Nepco Lake: Along shoreline	*980
Maps available for inspection at the City of Wisconsin Rapids, 444 West Grand Avenue, Wisconsin Rapids, Wisconsin.	

Wood County (Unincorporated Areas) (FEMA docket No. 7042)	
Yellow River: About 4,000 feet downstream of State Highway 73	*1,021
Just downstream of Weir No. 1	*1,078
Just upstream of Weir No. 1	*1,084
About 1.4 miles upstream of County Highway V	*1,238
Moccasin Creek: About 2,200 feet downstream of Soo Line Rail- road	*955
About 1.2 miles upstream of State Highway 73	*1,034
Wisconsin River: At southern county boundary	*928
Just downstream of Nekoosa Dam	*940
Just upstream of Nekoosa Dam	*950
Just downstream of Biron Dam	*1,022
Just upstream of Biron Dam	*1,035
About 3.0 miles upstream of Biron Dam	*1,037
Biron Overland Flow: About 800 feet downstream of North Biron Drive	*1,027
About 1,400 feet upstream of North Biron Drive	*1,032
Twomile Creek: Just upstream of Sampson Avenue	*995
Just downstream of County Trunk Highway W	*1,027
Nepco Lake: Along shoreline	*980
Maps available for inspection at the County Building, 400 Market Street, Wisconsin Rapids, Wisconsin.	

(Catalog of Federal Domestic Assistance No.
83.100, "Flood Insurance.")C.M. "Bud" Schaefer,
Administrator, Federal Insurance
Administration.

[FR Doc. 92-20995 Filed 8-31-92; 8:45 am]

BILLING CODE 6716-03-M

DEPARTMENT OF TRANSPORTATION

Maritime Administration

46 CFR Part 272

[Docket No. R-144]

RIN 2133-AA96

Administering Maintenance and Repair
Subsidy; Audit Requirements and
ProcedureAGENCY: Maritime Administration,
Department of Transportation.

ACTION: Correction of final rule.

SUMMARY: The Maritime Administration
(MARAD) is issuing this notice of
correction of a final rule which appeared
in the Federal Register on August 6, 1992
(54 FR 34689) concerning the
administration of maintenance and
repair subsidy.

EFFECTIVE DATE: August 6, 1992.

SUPPLEMENTARY INFORMATION: In the
August 6, 1992 final rule preamble, in the
paragraph with the heading Paperwork
Reduction Act, the cited OMB Approval
No. "2133-0006" is incorrect and is being
revised.

PART 272—[CORRECTED]

Accordingly, on page 34690 in the
Federal Register of August 6, 1992,
Column 2, the final rulemaking notice for
46 CFR part 272 is corrected by
amending the first sentence in the
paragraph with the heading Paperwork
Reduction Act, within the parentheses,
to remove the Approval No. "2133-
0006," and insert in its place the
Approval No. "2133-0007."

Dated: August 26, 1992.

James E. Saari,

Secretary, Maritime Administration.

[FR Doc. 92-20925 Filed 8-31-92; 8:45 am]

BILLING CODE 4910-31-M

46 CFR Part 298

[Docket No. R-145]

RIN 2133-AA97

Obligation Guarantees

AGENCY: Maritime Administration,
Department of Transportation.

ACTION: Correction of final rule.

SUMMARY: The Maritime Administration
(MARAD) is issuing this notice of
correction of a final rule which appeared
in the Federal Register on August 6, 1992
(54 FR 34690) concerning the calculation
of the Internal Rate of Return now
required with applications for obligation
guarantees.

EFFECTIVE DATE: August 6, 1992.

SUPPLEMENTARY INFORMATION: In the
August 6, 1992 final rule preamble, in the
paragraph with the heading Paperwork
Reduction Act, the cited OMB Approval
No. "2133-0006" is incorrect and is being
revised.

PART 298—[CORRECTED]

Accordingly, on page 34691 in the
Federal Register of August 6, 1992,
Column 3, the final rulemaking notice for

46 CFR part 298 is corrected by amending the first sentence in the paragraph with the heading Paperwork Reduction Act, within the parentheses, to remove the reference to "Approval No. 2133-0006," and insert in its place "Approval Nos. 2133-0005 and 2133-0018."

Dated: August 26, 1992.

James E. Saari,

Secretary, Maritime Administration.

[FR Doc. 92-20924 Filed 8-31-92; 8:45 am]

BILLING CODE 4910-31-M

FEDERAL MARITIME COMMISSION

46 CFR Parts 510, 514, 580 and 582

[Docket No. 92-27]

Filing Requirements for Anti-Rebate Certifications

AGENCY: Federal Maritime Commission.

ACTION: Final rule.

SUMMARY: The Federal Maritime Commission is amending its regulations which govern certification of freight forwarder and carrier policies and efforts to combat rebating in the foreign commerce of the United States. The amendments will reduce the annual certification filing requirement to every two years. The intent of this amendment is to reduce the cost imposed on regulated companies by these regulations and to reduce the cost incurred by the Commission in administering them, without loss of regulatory effectiveness.

DATES: Effective upon publication in the *Federal Register* except 46 CFR 514(c)(1)(iii) which is effective September 11, 1992.

FOR FURTHER INFORMATION CONTACT:

Bryant L. VanBrakle, Director, Bureau of Tariffs, Certification and Licensing, Federal Maritime Commission, 800 North Capitol Street, NW., Washington, DC 20573, (202) 523-5796.

or

Seymour Glanzer, Director, Bureau of Hearing Counsel, Federal Maritime Commission, 800 North Capitol Street, NW., Washington, DC 20573, (202) 523-5783.

SUPPLEMENTARY INFORMATION:

Background

Section 15 of the Shipping Act of 1984 ("1984 Act"), 46 U.S.C. app. 1714, mandates that the Federal Maritime Commission ("Commission" or "FMC") require the Chief Executive Officer ("CEO") of each common carrier to file with the Commission a written anti-

rebating certification ("ARC") under oath. Section 15 also authorizes the Commission to require the CEO of ocean freight forwarders to file ARCs under oath.

Part 582 of the Commission's rules, 46 CFR part 582, implements section 15 of the 1984 Act by establishing the content of ARCs and procedures governing their filing. Under part 582, the CEO of a common carrier in the foreign commerce of the United States must file an ARC with the Commission on or before December 31 of each year. Part 580, 46 CFR at 580.5(c)(2)(ii), governs tariff requirements regarding common carriers' ARCs. Part 514, 46 CFR at 514.1(c)(1)(iii), is the interim rule, published August 12, 1992, 57 FR 36247, which governs tariff requirements regarding common carriers' ARCs under the Automated Tariff Filing and Information System ("ATFI").

Similarly, part 510 of the Commission's rules, at 46 CFR 510.25, requires licensed ocean freight forwarders to file ARCs on or before December 31 of each year. The content of freight forwarders' ARCs and the procedures for filing them are governed by part 582, *supra*.

Section 15 of the 1984 Act also provides that whoever fails to file an ARC required by the Commission is liable to the United States for a civil penalty of not more than \$5,000 for each day the violation continues. Under parts 510, 514, 580 and 582 of the Commission's regulations, 46 CFR parts 510, 514, 580 and 582, carriers' tariffs may be canceled and freight forwarders' licenses may be suspended for failure to file required ARCs.

To reduce the administrative and cost burdens on the regulated industry and the Commission, without causing any appreciable loss of regulatory effectiveness, the Commission proposed to amend parts 510, 580 and 582 of its rules to require ARCs be filed every two years rather than annually. For administrative consistency, the proposed rule required that ARCs be filed by December 31 of each even-numbered year. The proposed rule also made technical changes to reflect the redesignation of the Commission's Bureau of Domestic Regulation as the Bureau of Tariffs, Certification and Licensing.

The proposed rule was published in the *Federal Register* on June 4, 1992, 57 FR 23563. Comments were due to be filed by July 7, 1992. Comments on the proposed rule were filed timely by the following parties:

1. New York Foreign Freight Forwarders and Brokers Association ("NYFFB")

2. Sea-Land Service, Inc. ("SeaLand")
3. Transpacific Westbound Rate Agreement ("TWRA")
4. Council of European and Japanese Shipowners Associations ("CENSA")
5. E.I. DuPont de Nemours and Company ("DuPont")
6. Crowley Maritime Corporation ("Crowley")
7. Pacific Coast Council of Customs Brokers and Freight Forwarders Associations, Inc. ("PCC")
8. International Association of NVOCCs ("IANVOCC")
9. National Customs Brokers and Forwarders Association of America, Inc. ("NCBFA")
10. A group of 15 South and Central American and Caribbean Conferences and Associations ("Conferences")¹
11. Inter-American Freight Conference ("IAFC")²

NYFFB, SeaLand, TWRA, and CENSA commend the proposed rule and fully support the text published by the Commission.

Dupont states that it generally opposes filing with the Commission of service contracts and their essential terms, as well as tariffs. Dupont asserts, however, that if the Commission continues to require tariff and service contract filing, the rule as proposed is "acceptable."

Crowley supports the proposed rule but voices its concern that this proceeding could be construed to signify a lessening of the Commission's resolve to carry out its enforcement program. There is no reason for such concern. This rulemaking is founded on the Commission's determination that the proposed changes will not reduce its regulatory effectiveness. This rule should not have any detrimental effect on the Commission's enforcement efforts designed to obtain statutory compliance and ensure equitable trading conditions in the U.S. ocean commerce.

PCC, IANVOCC and NCBFA support the proposed rule but ask the Commission to extend the filing period to three or more years. As several commentators observed, the ARC is intended to serve, and does serve, an important preventive function. It is a regular and frequent reminder to the CEOs of freight forwarders and carriers that they have particular Shipping Act obligations that must be memorialized, under oath, in periodic reaffirmations of their companies' commitments to abide by those obligations. Certification every

¹ Five member carriers, including SeaLand and a Crowley affiliate, did not join in these comments.

² Two members of the IAFC did not join in these comments.

two years appears sufficient to accomplish these purposes. Stretching such certifications beyond a two-year requirement may not achieve those purposes and could render them less effective. A longer than two year term also would appear to be beyond the scope of this proceeding and therefore require further notice and opportunity for comment. Accordingly, the Commission has concluded not to extend the filing period beyond two years.

The Conferences oppose adoption of the proposed rule for the stated reason that the rule "might be construed by various segments of the industry as a lessening of the Commission's resolve to fully enforce the Act." As aforementioned, there is no basis for such concern. This rule does not signify any lessening of the Commission's unwavering resolve to investigate and enforce Shipping Act violations and initiate appropriate enforcement actions.

The Conferences also ask the Commission to expand the scope of its ARC regulations to include "shippers, shippers' associations, maritime terminal operators, and brokers." Such request exceeds the scope of this rulemaking proceeding.

IAFC, based on an apparent misreading of the proposed rule, asserts the unfairness of singling out forwarders (but not carriers) for filing ARCs every two years. The proposed rule would apply to both forwarders and carriers.

After considering all of the comments filed in this proceeding, and for all of the foregoing reasons, the Commission has determined to adopt, in final form, the rule as originally set forth in the Notice of Proposed Rulemaking. In addition, although not referenced in the proposed rule, technical conforming changes are being made to part 510 at 46 CFR 510.16(a)(6). The word "annual" has been deleted from 46 CFR 510.16(a)(6), to ensure consistency with § 510.25 and to avoid potential misunderstandings. Appropriate changes also are being made to part 514 at 46 CFR 514.1(c)(1)(iii), the Commission's interim rule for ATFI, to ensure consistency with § 580.5(c)(2)(ii).

Although the Commission, as an independent regulatory agency, is not subject to Executive Order 12291, dated February 17, 1981, it nonetheless reviewed this rule in terms of that Order and has determined that this rule is not a "major rule" as defined in Executive Order 12291 because it will not result in:

- (1) annual effect on the economy of \$100 million or more;
- (2) a major increase in costs or prices for consumers, individual industries,

Federal, State or local government agencies, or geographic regions; or

(3) significant adverse effects on competition, employment, investment, productivity, innovations, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This rule reduces the administrative burdens and costs of freight forwarders, non-vessel operating common carriers and vessel operating ocean common carriers. Inasmuch as this reduction should be beneficial to such entities, the Federal Maritime Commission certifies, pursuant to section 605(b) of the Regulatory Flexibility Act, 5 U.S.C. 605(b), that this rule will not have a significant economic impact on a substantial number of small entities, including small businesses, small organizational units and small government jurisdictions.

This rule does not contain any collection of information requirements that require submission to the Office of Management and Budget ("OMB"). Therefore, OMB review is not required.

List of Subjects

46 CFR Part 510

Freight forwarders; Maritime carriers; Reporting and recordkeeping requirements; Surety bonds.

46 CFR Part 514

Barges; Cargo; Cargo vessels; Exports; Fees and user charges; Freight; Harbors; Imports; Maritime carriers; Motor carriers; Ports; Rates and fares; Reporting and recordkeeping requirements; Surety bonds; Trucks; Water carriers; Waterfront facilities; Water transportation.

46 CFR Part 580

Cargo; Cargo vessels; Freight; Exports; Harbors; Imports; Maritime carriers; Rates; Reporting and recordkeeping requirements; Surety bonds; Water carriers; Water transportation.

46 CFR Part 582

Maritime carriers; Penalties; Reporting and recordkeeping requirements.

Therefore, parts 510, 514, 580 and 582 of title 46, Code of Federal Regulations, are amended as follows:

PART 510—[AMENDED]

1. The authority citation for part 510 continues to read:

Authority: 5 U.S.C. 553, 46 U.S.C. app. 1702, 1707, 1709, 1710, 1712, 1714, 1716 and 1718; 21 U.S.C. 853a.

2. Section 510.16(a)(6) is amended by revising the first and second sentences to read as follows:

§ 510.16 Revocation or suspension of license.

(a) * * *

(6) Failure to file an anti-rebate certification as required by § 510.25 and part 582 of this chapter. Any licensed freight forwarder who fails to file an anti-rebate certification will be notified by Federal Register publication and by certified mail that if within forty-five (45) days from the date the certified notice is mailed the licensee does not either establish that the required anti-rebate certification was filed in accordance with § 510.25 and part 582 of this chapter or file the required anti-rebate certification, its license will be suspended until such time as it is reinstated by the Commission after an anti-rebate certification is filed. * * *

3. Section 510.25 is revised to read as follows:

§ 510.25 Anti-rebate certifications.

(a) Every licensed ocean freight forwarder shall file an anti-rebating certificate on or before December 31, 1992, and thereafter, on or before December 31 of each succeeding even-numbered calendar year.

(b) Every applicant for an ocean freight forwarder license shall file an anti-rebating certificate with its license application. Any application for an ocean freight forwarder license that does not include an anti-rebate certification in accordance with § 510.12 and part 582 of this chapter shall be rejected. Certificates filed with license applications shall be valid from the granting of an ocean freight forwarder license through the first succeeding December 31 of an even-numbered calendar year.

(c) The anti-rebating certificate shall comply with the requirements of part 582 of this chapter.

PART 514—[AMENDED]

4. The authority citation for part 514 continues to read:

Authority: 5 U.S.C. 552 and 553; 31 U.S.C. 9701; 46 U.S.C. app. 804, 812, 814-817(a), 820, 833a, 841a, 843, 844, 845, 845a, 845b, 847, 1702-1705, 1707-1709, 1712, 1714-1716, 1718 and 1722; and sec. 2(b) of Pub. L. 101-92, 103 Stat. 601.

5. Section 514.1(c)(1)(iii) (A) and (C) is revised to read as follows:

§ 514.1 Scope, purpose, requirements and penalties.

* * *

- (c) * * *
- (1) * * *
- (iii) * * *

(A) An anti-rebating certification shall be filed in paper format, as prescribed by part 582 of this chapter, by every common carrier in foreign commerce as a prerequisite to obtaining passport authority to file its initial tariff under this part, and thereafter, on each succeeding December 31 of an even-numbered calendar year. Except for the initial certification, the certification filed on each succeeding December 31 of an even-numbered calendar year shall be valid for the two calendar years following the December 31 filing date.

(C) Any common carrier who fails to file an anti-rebate certification as required by part 582 of this chapter will be notified by Federal Register publication and by certified mail that if, within forty-five (45) days from the date the certified notice is mailed, the common carrier does not either establish that the required anti-rebate certification was filed in accordance with this part and part 582 of this chapter, or file the required anti-rebate certification, its tariff(s) will be cancelled and attempted filings rejected.

PART 580—[AMENDED]

6. The authority citation for Part 580 continues to read:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1702-1705, 1707, 1709, 1710-1712, 1714-1716, 1718, and 1722.

7. Section 580.5(c)(2)(ii)(B) is revised to read as follows:

§ 580.5 Tariff contents.

- (c) * * *
- (2) * * *
- (ii) * * *

(B) In addition to the anti-rebate tariff provision, an anti-rebating certificate shall be filed by every common carrier with its initial tariff, and thereafter, on each succeeding December 31 of an even-numbered calendar year. The anti-rebating certificate shall comply with the requirements of part 582 of this chapter. Failure of a common carrier to file an anti-rebate certification with initial tariffs and publish notice of that certification in its tariff as required by this part and part 582 of this chapter shall result in rejection of that carrier's tariff. Any common carrier who fails to file an anti-rebate certification as required by part 582 of this chapter will be notified by Federal Register publication and by certified mail that if within forty-five (45) days from the date

the certified notice is mailed the common carrier does not either establish that the required anti-rebate certification was filed in accordance with this part and part 582 of this chapter or file the required anti-rebate certification, its tariff will be canceled, and in the event its rates are published in one or more conference tariffs, its name will be stricken from the list of carriers participating in those conference tariffs. The tariff(s) of any common carrier who files an anti-rebate certification after December 31 but before the end of the forty-five (45) days notice period will not be canceled; however, the common carrier will be subject to civil penalties as provided in part 582 of this chapter. After the forty-five (45) days, any common carrier that does not have an anti-rebate certification on file with the Commission will be notified by Federal Register publication and certified mail, return receipt requested, that its tariff(s) have been canceled or its name has been stricken from conference tariff(s).

PART 582—[AMENDED]

8. The authority citation for part 582 continues to read:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1701, 1702, 1707, 1709, 1712, and 1714-1716.

9. Section 582.3 is revised to read as follows:

§ 582.3 Reporting requirements.

(a) Every common carrier required by this part to file a written certification in the form prescribed by § 582.2, shall file such certification with its initial tariff and, thereafter, on or before December 31 of each succeeding even-numbered calendar year.

(b) Every licensed ocean freight forwarder, required by § 510.25 of this chapter to file a written certification in the form prescribed by § 582.2 of this part, shall file such certification on or before December 31, 1992, and thereafter, on or before December 31 of each succeeding even-numbered calendar year. Every applicant for an ocean freight forwarder license initially shall file such certification with its license application.

(c) The certification required by this section shall be valid from the initial filing of a tariff or granting of an ocean freight forwarder license through the first succeeding December 31 of an even-numbered calendar year.

(d) Every person other than a common carrier or ocean freight forwarder which is ordered by the Commission pursuant to § 582.2 to file a written certification

shall file such certification in the manner prescribed by the Commission.

(e) In those instances in which a single firm operates in more than one capacity, such as both a non-vessel-operating common carrier and an ocean freight forwarder, a single certificate may be submitted to satisfy the reporting requirements of this section.

Joseph C. Polking,

Secretary.

[FR Doc. 92-20819 Filed 8-31-92; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 90-476; RM-7343, RM-7652, RM-7653, RM-7654]

Radio Broadcasting Services; Cordova, Warrior, Holly Pond, Eva, Fairview and Falkville, AL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action substitutes Channel 223A for Channel 237A at Cordova, Alabama, and modifies the license of Radio South, Inc., for Station WFFN(FM) to specify operation on the substituted channel, and allots Channel 260A at Eva, Alabama, as its first local service. The coordinates for Channel 223A at Cordova are 33-40-38 and 87-11-33. The coordinates for Channel 260A at Eva are 34-20-00 and 86-45-00. This action also dismisses counterproposals filed by Warrior Communications and Ross Broadcasting Company, Inc. at their request pursuant to settlement agreements between each party and Radio South, Inc. See 55 FR 46078 (November 4, 1991). With this action, this proceeding is terminated.

DATES: Effective October 13, 1992. The window period for filing applications for Channel 260A at Eva will open on October 14, 1992, and close on November 13, 1992.

FOR FURTHER INFORMATION CONTACT: Victoria M. McCauley, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report Order, MM Docket No. 90476, adopted July 29, 1992, and released August 26, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may

also be purchased from the Commission's copy contractor, Downtown Copy Center, (202) 452-1422, 1990 M Street, NW., suite 640, Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Alabama, is amended by removing Channel 237A and adding Channel 223A at Cordova, and by adding Eva, Channel 260A.

Federal Communications Commission.

Michael C. Ruger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-20930 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 89-290; RM-6607, RM-6801, RM-6958]

Radio Broadcasting Services; Magnolia, Mena, and Murfreesboro, AR

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document substitutes Channel 271C2 for Channel 269A at Mena, Arkansas, and modifies the license of Station KENA, Mena, Arkansas, to specify operation on Channel 271C2. This document also substitutes Channel 258C3 for Channel 237A at Murfreesboro, Arkansas, and modifies the license of Station KMTB, Murfreesboro, Arkansas, to specify operation on Channel 258C3. Finally, this document dismisses a proposal to allot Channel 271A to Magnolia, Arkansas. See 54 FR 27904, published July 3, 1989. The reference coordinates for the Channel 271C2 allotment at Mena, Arkansas, are 34-30-05 and 94-20-10. The reference coordinates for the Channel 258C3 allotment at Murfreesboro, Arkansas, are 34-05-44 and 93-41-31. With this action, the proceeding is terminated.

EFFECTIVE DATE: October 13, 1992.

FOR FURTHER INFORMATION CONTACT: Robert Hayne, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report

and Order, MM Docket No. 89-290, adopted July 31, 1992, and released August 26, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, Downtown Copy Center, (202) 452-1422, 1990 M Street, NW., suite 640, Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Arkansas, is amended by removing Channel 269A and adding Channel 271C2 at Mena, and by removing Channel 237A and adding Channel 258C3 at Murfreesboro.

Federal Communications Commission.

Michael C. Ruger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-20933 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 92-108; RM-7970]

Radio Broadcasting Services; St. Joseph, MN

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allots Channel 225C3 to St. Joseph, Minnesota, as that community's first local service in response to a petition filed by St. Joseph Broadcasters. See 57 FR 21919, May 26, 1992. The coordinates for Channel 225C3 are 45-37-14 and 94-22-05. There is a site restriction 7.3 kilometers (4.5 miles) northwest of the community. With this action, this proceeding is terminated.

DATES: Effective October 13, 1992. The window period for filing applications for Channel 225C3 at St. Joseph will open on October 14, 1992, and close on November 13, 1992.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 92-108, adopted July 30, 1992, and released August 26, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, Downtown Copy Center, 1990 M Street, NW., suite 640, Washington, DC 20036, (202) 452-1422.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Minnesota, is amended by adding St. Joseph, Channel 225C3.

Federal Communications Commission.

Michael C. Ruger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-20931 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 92-113; RM-7983]

Radio Broadcasting Services; Huntsville, TX

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of New Wave Communication Group, Inc., permittee of Station KVST-FM, Channel 278A, Huntsville, Texas, substitutes Channel 279C3 for Channel 278A at Huntsville, and modifies Station KVST-FM's construction permit to specify operation on the higher powered channel. See 57 FR 2190, May 26, 1992. Channel 279C3 can be allotted to Huntsville in compliance with the Commission's minimum distance separation requirements with a site restriction of 2.4 kilometers (1.5 miles) east to accommodate New Wave's desired site. The coordinates for Channel 279C3 are 30-43-24 and 95-31-

30. With this action, this proceeding is terminated.

EFFECTIVE DATE: October 13, 1992.

FOR FURTHER INFORMATION CONTACT: Pamela Blumenthal, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 92-113, adopted July 31, 1992, and released August 26, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, Downtown Copy Center, (202) 452-1422, 1990 M Street, NW., suite 640, Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Texas, is amended by removing Channel 278A and adding Channel 279C3 at Huntsville.

Federal Communications Commission.

Michael C. Ruger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-20934 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 661

[Docket No. 920412-2112]

Ocean Salmon Fisheries off the Coasts of Washington, Oregon, and California

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Reopening and inseason adjustments.

SUMMARY: NMFS announces that the commercial fishery from the U.S.-Canada border to Cape Falcon, Oregon, will reopen for 3 days on August 20-22, 1992, with a possession and landing limit of 44 coho salmon. This fishery was closed August 14, 1992, upon the projected attainment of the coho salmon harvest guideline. The Director,

Northwest Region, NMFS (Regional Director), has determined that a sufficient number of coho salmon remain to allow reopening of this fishery for 3 days with an adjusted possession and landing limit for coho salmon. This action is intended to maximize the harvest of coho salmon without exceeding the ocean share allocated to the commercial fishery in this subarea.

DATES: Effective at 0001 hours local time, August 20, 1992, through 2400 hours local time, August 22, 1992. Actual notice to affected fishermen was given prior to that time through a special telephone hotline and U.S. Coast Guard Notice to Mariners broadcasts as provided by 50 CFR 661.23. Comments will be accepted through September 15, 1992.

ADDRESSES: Comments may be mailed to Rolland A. Schmitt, Director, Northwest Region, National Marine Fisheries Service, NOAA, 7600 Sand Point Way NE., BIN C15700-Bldg. 1, Seattle, WA 98115-0070. Information relevant to this notice has been compiled in aggregate form and is available for public review during business hours at the office of the NMFS Northwest Regional Director.

FOR FURTHER INFORMATION CONTACT: William L. Robinson at (206) 526-6140.

SUPPLEMENTARY INFORMATION: In its emergency interim rule and notice of 1992 management measures (57 FR 19388, May 6, 1992), NMFS announced that the 1992 commercial fishery between the U.S.-Canada border and Cape Falcon, Oregon, would open July 20 and continue through the earliest of August 31 or attainment of harvest guidelines of either 18,100 coho salmon or 4,400 chinook salmon.

These harvest guidelines have since been revised to be 17,600 coho salmon and 9,700 chinook salmon (57 FR 36021, August 12, 1992).

Preseason restrictions for the July/August commercial fishery included a cycle of 2 days open and 3 days closed, a possession and landing limit of 30 coho salmon per opening, and gear limited to 6-inch plugs or larger and no more than 4 spreads per line. Inseason actions were taken such that this fishery's subsequent open periods were for 3 days each on July 25-27, July 31-August 2, August 6-8, and August 12-14 with a possession and landing limit of 44 coho salmon for each open period (57 FR 34085, August 3, 1992; 57 FR 34883, August 7, 1992; 57 FR 36021, August 12, 1992; 57 FR 37906, August 21, 1992). It was anticipated that the harvest guideline for coho salmon would be fully harvested during the last period and the fishery in this subarea was closed

effective 2400 hours local time, August 14, 1992.

Based on the best available information on August 18, 1992, the commercial catch in the subarea from the U.S.-Canada border to Cape Falcon during the 5 open periods totaled about 15,400 coho salmon and about 7,900 chinook salmon. The remainder of the coho salmon harvest guideline is projected to be harvested during a 3-day fishing period with an appropriate adjustment to the possession and landing limit. Therefore, the commercial fishery in the subarea from the U.S.-Canada border to Cape Falcon will open for 3 days, effective 0001 hours local time, August 20 through 2400 hours local time, August 22, 1992. Each vessel may possess, land and deliver not more than 44 coho salmon for this open period. Modifications of fishing seasons and limited retention regulations are authorized by regulations at 50 CFR 661.21(b)(1) (i) and (ii).

In accordance with the inseason notice procedures of 50 CFR 661.23, actual notice to fishermen of this action was given prior to 0001 hours local time August 20, 1992, by telephone hotline number (206) 526-6667 or (800) 662-9825 and by U.S. Coast Guard Notice to Mariners broadcasts on Channel 16 VHF-FM and 2182 KHz.

The Regional Director consulted with representatives of the Pacific Fishery Management Council, the Washington Department of Fisheries, and the Oregon Department of Fish and Wildlife regarding the reopening and adjustments affecting the commercial fishery between the U.S.-Canada border and Cape Falcon. The States of Washington and Oregon will manage the commercial fishery in State waters adjacent to this area of the exclusive economic zone in accordance with this Federal action. This notice does not apply to treaty Indian fisheries or to other fisheries that may be operating in other areas.

Because of the need for immediate action, the Secretary of Commerce has determined that good cause exists for this notice to be issued without affording a prior opportunity for public comment.

Classification

This action is authorized by 50 CFR 661.23 and is in compliance with Executive Order 12291.

List of Subjects in 50 CFR Part 661

Fisheries, Fishing, Indians, Reporting and recordkeeping requirements.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: August 26, 1992.

David S. Crestin,

*Acting Director, Office of Fisheries
Conservation and Management, National
Marine Fisheries Service.*

[FR Doc. 92-20991 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-22-M

Proposed Rules

Federal Register

Vol. 57, No. 170

Tuesday, September 1, 1992

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Rural Electrification Administration

7 CFR Part 1744

Borrower Investments—Telephone Loan Program

AGENCY: Rural Electrification Administration, USDA.

ACTION: Proposed rule.

SUMMARY: The Rural Electrification Administration (REA) proposes to add new subpart E to part 1744 on the types of investments REA telephone borrowers may make without prior approval of the Administrator of REA. REA also proposes to add the procedure for the treatment of investments in rural development projects when determining a borrower's allowable distribution of capital.

This proposed rule aims to promote economic growth in the communities served by REA telephone borrowers by making available additional sources of funding for rural economic development projects.

DATES: Comments concerning this proposed rule must be received by REA or bear a postmark or its equivalent no later than November 2, 1992.

ADDRESSES: Submit written comments to Matthew Link, Director, Rural Telephone Bank Management Staff, U.S. Department of Agriculture, Rural Electrification Administration, room 2832-S, 14th and Independence Avenue, SW., Washington, DC 20250-1500. REA requests an original and three copies of all comments (7 CFR part 1700). All comments received will be made available for inspection at room 2238 South Building (address as above) between 8:30 a.m. and 5 p.m. (7 CFR 1.27(b)).

FOR FURTHER INFORMATION CONTACT: Cheryl Gamboney, Management Analyst, Rural Telephone Bank Management Staff, at the address listed above, telephone number (202) 720-0415.

SUPPLEMENTARY INFORMATION:

Executive Order 12291

This proposed rule has been issued in conformance with Executive Order 12291 and Departmental Regulation 1512-1. This action has been classified as "nonmajor" because it does not meet the criteria for a major regulation as established by the Order.

Executive Order 12778

This proposed rule has been reviewed under Executive Order 12778, Civil Justice Reform. This proposed rule is intended to have retroactive effect with respect to investments in rural development projects. This proposed rule is not intended: (1) To have preemptive effect with respect to any state or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule; and (2) To require administrative proceedings before parties may file suit challenging the provisions of this rule.

Regulatory Flexibility Act Certification

The Administrator has determined that this proposed rule will not have a significant economic impact on a substantial number of small entities as defined in the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) because few borrowers of REA loans meet the requirements for small entities. Further, the regulations are applied equally to all borrowers.

Information Collection and Recordkeeping Requirements

In compliance with the Office of Management and Budget (OMB) regulations (5 CFR part 1320) which implements the Paperwork Reduction Act of 1980 (Pub. L. 96-511) and section 3504 of that Act, a portion of the information collection and recordkeeping requirements contained in this proposed rule have been approved by OMB under control number 0572-0031. The uncleared portion of the information collection requirements have been submitted to OMB for review. Comments concerning these requirements should be directed to the Office of Information and Regulatory Affairs of OMB, Attention: Desk Officer for USDA, room 3201, NEOB, Washington, DC 20402.

National Environmental Policy Act Certification

The Administrator has determined that this proposed rule will not significantly affect the quality of the human environment as defined by the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*). Therefore, this action does not require an environmental impact statement or assessment.

Catalog of Federal Domestic Assistance

The program described by this proposed rule is listed in the Catalog of Federal Domestic Assistance Programs under number 10.851, Rural Telephone Loans and Loan Guarantees and 10.852, Rural Telephone Bank Loans. This catalog is available on a subscription basis from the Superintendent of Documents, the United States Government Printing Office, Washington, DC 20402.

Executive Order 12372

This proposed rule is excluded from the scope of Executive Order 12372, Intergovernmental Consultation. A Notice of Final rule entitled Department Programs and Activities Excluded from Executive Order 12372 (50 FR 47034) exempts REA loans and loan guarantees and RTB loans, to governmental and nongovernmental entities from coverage under this Order.

Background

Section 2356 of the Rural Economic Development Act of 1990 (RED Act) (7 U.S.C. 926) amended the Rural Electrification Act of 1936 (RE Act) (7 U.S.C. 901 *et seq.*) to enable an REA telephone borrower to invest in rural development projects without prior approval of the Administrator of REA. Specifically, this new section of the RE Act allows certain borrowers to invest up to one-third of their net worth in rural development projects without prior approval of the Administrator of REA. In particular, those borrowers that have a net worth to total assets ratio of at least 20 percent do not require REA approval for such projects. Before the RED Act, all REA telephone borrowers were required to obtain REA approval prior to investing in rural development projects.

This regulation could potentially affect rural communities and businesses

served by the REA telephone borrowers that have a high enough net worth to total assets ratio and choose to invest their funds in rural economic development projects. Total funding available from all 908 reporting telephone borrowers amounted to \$2.4 billion as of December 31, 1990 (one-third of net worth). Eligible telephone borrowers that choose to invest in rural development projects could benefit both directly, through returns on their rural development project investments, and indirectly if the local economy grows, generating increased demand for telephone services.

The requirements of the RED Act have been incorporated into the standard form of mortgage between REA and its borrowers. This proposed rule clarifies the provisions of the RED Act and sets forth REA's policy concerning borrowers' investments in rural development projects.

List of Subjects in 7 CFR Part 1744

Accounting, Loan programs-communications, Reporting and recordkeeping requirements, Rural areas, Telephone.

For reasons set forth in the preamble, REA proposes to add new subparts D and E to 7 CFR part 1744 as follows:

PART 1744—POST-LOAN POLICIES AND PROCEDURES COMMON TO GUARANTEED AND INSURED TELEPHONE LOANS

1. The authority citation for part 1744 continues to read as follows:

Authority: 7 U.S.C. 901 *et seq.*, 7 U.S.C. 1921 *et seq.*

2. Subpart D is added and reserved and subpart E is added as follows:

Subpart E—Borrower Investments

- Sec.
- 1744.200 General statement.
- 1744.201 Definitions.
- 1744.202 Borrowers may make qualified investments without prior approval of the Administrator.
- 1744.203 Determinations and application of limitations described in § 1744.202.
- 1744.204 Determining whether a rural development investment is within the limits of the maximum investment ratio.
- 1744.205 Rural development investments that exceed the maximum investment ratio.
- 1744.206 Rural development investments before November 28, 1990.
- 1744.207 Records.
- 1744.208 Effect of this subpart on REA loan contract and mortgage.
- 1744.209 OMB control number.

Subpart E—Borrower Investments

§ 1744.200 General statement.

REA telephone borrowers are encouraged to utilize their own funds to participate in the economic development of rural areas, provided that such activity does not impair a borrower's ability to provide modern telecommunications services at reasonable rates or to repay its indebtedness to REA and other lenders. When considering loans, investments, or guarantees, borrowers are expected to act in accordance with prudent business practices and in conformity with the laws of the jurisdictions in which they serve.

§ 1744.201 Definitions.

As used in this subpart:

Administrator means the Administrator of the Rural Electrification Administration (REA).

Affiliated company means any organization that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the borrower.

Borrower means any organization which has an outstanding loan made or guaranteed by REA, or which is seeking such financing.

Guarantee means to undertake collaterally to answer for the payment of another's debt or the performance of another's duty, liability, or obligation, including, without limitation, the obligations of affiliated companies. Some examples of such guarantees would include:

- (1) Guarantees of payment or collection on a note or other debt instrument;
- (2) Issuing performance bonds or completion bonds; or
- (3) Cosigning leases or other obligations of third parties.

Maximum investment ratio is defined in § 1744.202(e).

Minimum total assets ratio is defined in § 1744.202(b).

Net plant means the sum of the balances of the following accounts of the borrower:

Account Names	Number
(1) Telecommunications plant in service.	2001
(2) Property held for future telecommunications use.	2002
(3) Telecommunications plant under construction-short term.	2003
(4) Telecommunications plant under construction-long term.	2004

Account Names	Number
(5) Telecommunications plant adjustment.	2005
(6) Nonoperating plant.	2006
(7) Goodwill.	2007
(8) Less accumulated depreciation.	3100 through 3300s
(9) Less accumulated amortization.	3400 through 3600s

All references to account numbers are to the Uniform System of Accounts (47 CFR part 32).

Net worth means the sum of the balances of the following accounts of the borrower:

Account Names	Number
(1) Capital stock.	4510
(2) Additional paid-in capital.	4520
(3) Treasury stock.	4530
(4) Other capital.	4540
(5) Retained earnings.	4550

For nonprofit organizations, owners' equity is shown in subaccounts of 4540 and 4550. All references regarding account numbers are to the Uniform System of Accounts (47 CFR part 32).

Qualified investment is defined in § 1744.202(c).

REA means the Rural Electrification Administration, an agency of the United States Department of Agriculture.

RE Act means the Rural Electrification Act of 1936, as amended (7 U.S.C. 901 *et seq.*).

REA mortgage means the instrument creating a lien on or security interest in the borrower's assets in connection with a loan made or guaranteed under the RE Act.

Rural development investment is defined in § 1744.202(d).

Total assets means the sum of the balances of the following accounts of the borrower:

Account Names	Number
(1) Current assets.	1100s through 1300s
(2) Noncurrent assets.	1400s through 1500s
(3) Total telecommunications plant.	2001 through 2007
(4) Less accumulated depreciation.	3100 through 3300s
(5) Less accumulated amortization.	3400 through 3600s

All references regarding account numbers are to the Uniform System of Accounts (47 CFR part 32).

Uniform System of Accounts means the Federal Communications Commission Uniform System of

Accounts for Telecommunications Companies (47 CFR part 32) as supplemented by 7 CFR part 1770, Accounting Requirements for REA Telephone Borrowers.

§ 1744.202 Borrowers may make qualified investments without prior approval of the Administrator.

(a) A borrower that equals or exceeds the minimum total assets ratio, defined in § 1744.202(b), may make a qualified investment, defined in § 1744.202(c), without prior written approval of the Administrator.

(b) The minimum total assets ratio means the borrower's net worth is at least twenty percent of its total assets including the proposed qualified investment.

(c) A qualified investment is a rural development investment, defined in § 1744.202(d), meeting the following criteria:

(1) Unless the borrower's commitment is as guarantor, the borrower receives any financial return accruing to such investment, or the borrower's proportionate share of such return;

(2) Unless the borrower's commitment is as guarantor, the borrower retains title to any asset acquired with such investment, or the borrower's proportionate share of such title; and

(3) The funds committed are the borrower's own funds, provided that a rural development investment will not be considered to be a qualified investment to the extent that the amount of such investments exceeds the borrower's maximum investment ratio (see § 1744.202(e)). As used in this paragraph, own funds shall mean money belonging to the borrower other than:

(i) Proceeds of loans made, guaranteed or lien accommodated by REA;

(ii) Funds necessary to make timely payments of principal and interest on loans made, guaranteed or lien accommodated by REA; and

(iii) Funds on deposit in the cash construction fund-trustee account, as defined in the borrower's loan contract with REA.

(d) A rural development investment is an investment, extension of credit, advance, or guarantee by a borrower for a period longer than one year and for one or more of the following purposes:

(1) Improve the economic well-being of rural residents and alleviate the problems of low income, elderly, minority, and otherwise disadvantaged rural residents;

(2) Improve the business and employment opportunities, occupational training and employment services, health care services, educational

opportunities, energy utilization and availability, housing, transportation, community services, community facilities, water supplies, sewage and solid waste management systems, credit availability, and accessibility to and delivery of private and public financial resources in the maintenance and creation of jobs in rural areas;

(3) Improve state and local government management capabilities, institutions, and programs related to rural development and expand educational and training opportunities for state and local officials, particularly in small rural communities;

(4) Strengthen the family farm system; or

(5) Maintain and protect the environment and natural resources of rural areas.

As used in paragraph (d) of this section, the term rural development investment shall include investments by a borrower in its own name, in affiliated companies, and in entities not affiliated with the borrower.

(e) Maximum investment ratio means that the aggregate of all qualified investments by the borrower including the proposed qualified investment shall not be more than one-third of the net worth of the borrower.

§ 1744.203 Determinations and application of limitations described in § 1744.202.

(a) REA will not include qualified investments, including qualified investments in affiliated companies, in calculating the amount of dividend or capital distributions a borrower may make under its REA mortgage.

(b) A borrower's investment in its net plant shall not be considered a rural development investment for purposes of calculating the maximum investment ratio or the minimum total assets ratio.

(c) The borrower's net plant, net worth, and total assets shall be determined using the balances of the respective accounts of the borrower as of December 31 of the last complete calendar year preceding the date on which the borrower's maximum investment ratio and minimum total assets ratio are calculated.

(d) All determinations required to be made under 7 U.S.C. 926 or this subpart will be made in accordance with the Uniform System of Accounts (USoA) (47 CFR part 32). References to specific USoA accounts shall include revised or replacement accounts.

§ 1744.204 Determining whether a rural development investment is within the limits of the maximum investment ratio.

For purposes of determining whether a rural development investment is

within the limits of the borrower's maximum investment ratio or the minimum total assets ratio, the amount of the qualified investment shall be the total amount of funds committed to the rural development project as of the date of determination and a reasonable estimate of the amount the borrower is committed to provide to the rural development project in future years. The total amount of funds committed includes the principal amount of loans, advances, and guarantees made by the borrower to the rural development project.

§ 1744.205 Rural development investments that exceed the maximum investment ratio.

(a) Each borrower is authorized to make expenditures other than qualified investments only in accordance with the provisions of the borrower's mortgage with REA. Without REA's approval, the portion of any expenditure of funds or commitment to expend funds for any rural development investment that will exceed the borrower's maximum investment ratio or cause the borrower to fall below the minimum total assets ratio, must comply with the provisions of the REA mortgage.

(b) REA will consider, on a case-by-case basis, requests for approval of expenditures not constituting qualified investments. REA may condition such approval, if granted, on such requirements and restrictions as REA may determine to be in the best interests of the Government, including, without limitation, the borrower's agreement to limit dividends or distributions of capital by an amount specified by REA. Requests for such approvals must be submitted in writing to the relevant REA regional office and shall include:

(1) A description of the rural development project and the type of investment to be made, such as a loan, guarantee, stock purchase or equity investment;

(2) A reasonable estimate of the amount the borrower is committed to provide to the rural development project including expenditures that may be required in the future; and

(3) A pro forma balance sheet and cash flow statement for the period covering the borrower's future commitments to the rural development project.

(b) In determining whether to approve a rural development investment that may cause the borrower to exceed the maximum investment ratio or to fall below the minimum total assets ratio in the future, REA will consider annual increases to the borrower's net worth

and total assets as might be reasonably anticipated from the borrower's normal operations.

(c) A borrower shall not make a qualified investment or a rural development investment which jeopardizes:

- (1) The security of loans made or guaranteed by REA; or
- (2) The borrower's ability to repay such loans under the terms and conditions as agreed.

§ 1744.206 Rural development investments before November 28, 1990.

All investments made by a borrower shall be subject to the provisions of this subpart, regardless of when the investment was made or whether it has been approved by REA. Any restrictions required by REA as a condition to approving a rural development investment before November 28, 1990, shall continue to be in effect to the extent that such investment exceeds the maximum investment ratio or causes the borrower to fall below the minimum total assets ratio.

§ 1744.207 Records.

(a) The records of borrowers, including records relating to qualified investments, shall be subject to the auditing procedures prescribed in part 1773 of this chapter. REA reserves the right to review the records of the borrower relating to qualified investments to determine if the borrower is in compliance with this subpart.

(b) Borrowers shall report to REA on the end-of-year operating report, REA Form 479, the current status and principal amount of each qualified investment it has made or is committed to make pursuant to § 1744.202.

§ 1744.208 Effect of this subpart on REA loan contract and mortgage.

(a) Except as expressly provided in this subpart, the borrower shall comply with all provisions of its loan contract with REA, its notes issued to REA, and the REA mortgage, including all provisions thereof relating to investments not covered by this subpart.

(b) Nothing in this subpart shall affect any rights of supplemental lenders under the REA mortgage, or other creditors of the borrower, to limit a borrower's investments, loans and guarantees to levels below those permitted in § 1744.202.

(c) As used in paragraph (b) of this section, supplemental lender means a creditor of the borrower, other than REA, whose loan to the borrower is secured by the REA mortgage.

§ 1744.209 OMB control number.

A portion of the information collection requirements in this subpart have been approved by the Office of Management and Budget and assigned OMB control number 0572-0031. The unclassified portion of the information collection requirements have been submitted to OMB for review.

Dated: August 24, 1992.

James B. Huff, Sr.,

Administrator.

[FR Doc 92-20816 Filed 8-31-92; 8:45 am]

BILLING CODE 3410-15-F

Farmers Home Administration

7 CFR Parts 1902 and 1930

RIN 0575-AB31

Supervised Bank Accounts and Multi-Housing Reserve Funds

AGENCY: Farmers Home Administration, USDA.

ACTION: Proposed rule.

SUMMARY: The Agency seeks to require reserve accounts to be subject to counter signature by an Agency official before funds can be withdrawn. The intended effect of this action is to reduce the incidence of fraud, waste, and abuse by requiring reserve funds to be subject to Agency counter signature for all withdrawals. This action is intended to prevent abuses before they occur.

DATES: Written comments must be received on or before November 2, 1992.

ADDRESSES: Submit written comments, in duplicate, to the Office of the Chief, Regulations Analysis and Control Branch, Farmers Home Administration, room 6348, South Building, Washington, DC 20250. All written comments will be available for public inspection during regular working hours at the above address.

FOR FURTHER INFORMATION CONTACT: James E. Vollmer, Senior Loan Specialist, Multi-Family Housing Servicing and Property Management Division, Farmers Home Administration, USDA, Washington, DC 20250; telephone: (202) 720-1060.

SUPPLEMENTARY INFORMATION:

Classification

This action has been reviewed under USDA procedures established in Departmental Regulation 1512-1, which implements Executive Order 12291 and has been determined to be non-major. This action will not result in an annual effect on the economy of \$100 million or more; a major increase in costs or prices for consumers, individual industries,

Federal State, or local government agencies or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Agency seeks to improve FmHA oversight of reserve accounts in its multi-housing programs by requiring them to be subject to counter-signature in a supervised bank account. Reserve accounts are presently required to be funded and used in accordance with Agency regulations, which already requires the prior consent of the Agency prior to withdrawing reserve funds. However, internal Agency reviews and audits conducted by the Office of the Inspector General (OIG) are highlighting various violations of Agency regulations.

The most common concerns include the withdrawal of reserve funds without Agency consent, funds being pledged as security for other loans without Agency knowledge, withdrawal of interest earned on reserve funds for nonproject purposes, lenders withdrawing funds for application on other defaulted loans, reserve funds withdrawn at a lending institution for application on other debts, and reserve accounts held at a lending institution for a short period of time before transferring to another institution.

The Agency expects to curtail reserve fund abuses by shifting emphasis to oversee compliance through procedures aimed at preventing abuses (e.g., requiring the counter signature of Agency officials for withdrawal of reserve funds which are to be placed in a supervised bank account). The Agency's present procedures rely on oversight through monitoring routines with the threat of potential punitive measures being imposed should violations be discovered.

The Agency solicits comments concerning the impact of the proposed rules on those holding reserve funds in money market accounts, bonds, or financial holdings other than in checking or savings accounts in federally insured institutions. The Agency desires to ensure that the proposed rules to reduce reserve account abuses are met in a practical manner without inadvertently imposing severe financial hardship on existing borrowers. The Agency is aware that the proposed rule may result in some borrowers having to pay financial fees or penalties which will erode reserve funds and is concerned that such adverse impacts be minimized.

to the extent practical. The Agency also solicits other alternative approaches to curtail reserve account abuses.

Environmental Impact Statement

This document has been reviewed in accordance with 7 CFR part 1940, subpart C, "Environmental Program." It is the determination of FmHA that the proposed action does not constitute a major Federal action significantly affecting the quality of the human environment, and in accordance with the National Environmental Policy Act of 1969, Public Law 91-190, an Environmental Impact Statement is not required.

Regulatory Flexibility Act

The Administrator, FmHA, has determined this action will not have a significant economic impact on a substantial number or small entities as defined by the Regulatory Flexibility Act (5 U.S.C. 601). Since this action will not have a significant economic impact on a substantial number of small entities, a Regulatory Impact Analysis is not needed.

Paperwork Reduction Act

The collection of information requirements contained in this regulation have been submitted to the Office of Management and Budget for review under section 3504(h) of the Paperwork Reduction Act of 1980. Public reporting burden for this collection of information is estimated to vary from 1 minute to 15 minutes per response, with an average of 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Agriculture, Clearance Officer, OIRM, room 404-W, Washington, DC 20250; and to the Office of Management and Budget, Attention: Desk Officer for the Farmers Home Administration, Washington, DC 20503.

Intergovernmental Review

The programs affected are listed in the Catalog of Federal Domestic Assistance under numbers 10.405—Farm Labor Housing Loans and Grants, 10.415—Rural Rental Housing Loans, and 10.427—Rural Rental Assistance Payments and are subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. (7 CFR part 3105, subpart V; 48

FR 29112, June 24, 1983; 49 FR 2267, May 31, 1984; 59 FR 14068, April 10, 1985).

Civil Justice Reform

This proposed regulation has been reviewed in light of Executive Order 12778 and meets the applicable standards provided in sections 2(a) and 2 (b)(2) of that Order. Provisions within this part which are inconsistent with state law are controlling. All administrative remedies pursuant to 7 CFR part 1900, subpart B must be exhausted prior to filing suit.

List of Subjects

7 CFR Part 1902

Accounting, Banks, Banking, Grant Programs—Housing and Community Development, Loan Programs—Agriculture, Loan Programs—Housing and Community Development.

7 CFR Part 1930

Accounting, Administrative Practice and Procedure, Grant Programs—Housing and Community Development, Loan Programs—Housing and Community Development, Low and Moderate Income Housing—Rental, Reporting and recordkeeping requirements.

Accordingly, as proposed, title 7, chapter XVIII of the Code of Federal Regulations is amended as follows:

PART 1902—SUPERVISED BANK ACCOUNTS

1. The authority citation for part 1902 continues to read as follows:

Authority: 7 U.S.C. 1989; 42 U.S.C. 1480; 5 U.S.C. 301; 7 CFR 2.23; 7 CFR 2.70.

Subpart A—Disbursement of Loan, Grant, or Other Funds

2. The heading of subpart A of part 1902 is revised to read as follows: "Disbursement of Loan, Grant or Other Funds."

3. Section 1902.1 is amended by revising paragraphs (j) and (k) to read as follows:

§ 1902.1 General.

(j) Form FmHA 402-1 provides for the deposit of funds in a supervised bank account to assure the performance of the borrower's obligation to FmHA in connection with loan, grant, or other funds.

(1) Monthly bank statements will not normally be required for Multiple Family Housing (MFH) accounts and if received, will not normally require reconciliation. It is expected that bank statements will normally be forwarded

annually to the Agency. See § 1902.14 of this subpart for guidance.

(2) Reserve accounts for MFH borrowers which exceed the federal insurance levels must be collateralized in accordance with the principles set out in §§ 1902.6 and 1902.7 of this subpart for guidance.

(k) "Interest-Bearing Deposit Agreement." (Exhibit B of this subpart) provides for the deposit of loan or grant funds that are not required for immediate disbursement in specified interest-bearing deposits, and it is executed in conjunction with Form FmHA 1940-1.

§ 1902.2 [Amended]

4. Section 1902.2(a)(4) is amended by revising the phrase "loan and grant funds" in the first sentence to read "loan, grant, or other funds"; and by adding the following sentence at the end of the paragraph: "However, when used in conjunction with MFH reserve accounts, such accounts will remain in place as long as the borrower is indebted to the Agency."

§ 1902.2 [Amended]

5. Section 1902.2(a)(6) is amended in the first sentence by revising the words "County Supervisor" to read "authorized FmHA Official"; and by adding the following sentence at the end of the paragraph: "This provision is not intended to limit MFH reserve accounts from being placed in a supervised bank account for as long as the borrower is indebted to the Agency."

§ 1902.2 [Amended]

6. Section 1902.2(a)(7) is amended by removing the parenthetical phrase at the end of the sentence.

§ 1902.9 [Amended]

7. Section 1902.9(b) is amended by removing the period at the end of the introductory text and adding the following: ", unless this requirement is waived by the District Director for MFH reserve accounts."

8. Section 1902.9 is amended by revising paragraph (b)(2) to read as follows:

§ 1902.9 Deposits.

(b) . . .

(2) Funds other than loan or grant funds may be deposited by the borrower in those instances where an agreement is reached between the District Director or County Supervisor and the borrower, whereby the borrower will make deposits of income from any source directly into the supervised bank account. In such instances the borrower

will be instructed to prepare the deposit slip in the manner described in § 1902.9(a)(5); however, the District Director may waive having copies of the deposit slip required to be distributed to the case file for MFH reserve accounts.

9. Section 1902.14 is amended by revising paragraph (a) to read as follows:

§ 1902.14 Reconciliation of accounts.

(a) A checking account statement will be obtained periodically in accordance with established practices in the area. If the checking account statement does not include sufficient information to reconcile the account (the name of the payee or the check number and the account of each check, i.e., a negotiable demand draft drawn on a financial institution), the original cancelled check or either a microfilm copy or other reasonable facsimile of the cancelled check must be provided to the District or County Office with the statement. Checking account statements will be reconciled promptly with District or County Office records. The person making the reconciliation will initial the record and indicate the date of the action. The District Director may waive the receipt of copies of frequent checking account statements for reconciliation purposes for MFH reserve accounts and may instead require a checking account statement as needed, an annual checking account statement, or audit(s), when they are sufficient, in combination with other Agency record systems used to track reserve funds, to ensure reserve funds are at authorized levels.

PART 1930—GENERAL

10. The authority citation for part 1930 continues to read as follows:

Authority: 42 U.S.C. 1480; 7 CFR 2.23; 2.70.

Subpart C—Management and Supervision of Multiple Family Housing Borrowers and Grant Recipients

11. In paragraph XIII, the introductory text of paragraph B, and paragraphs B1, B2 introductory text, and B2 a, b, and c of Exhibit B of Subpart C of Part 1930 are revised to read as follows:

Exhibit B—Multiple Housing Management Handbook

XIII Accounting and Reporting Requirements and Financial Management Analysis

B. Accounting System. A bookkeeping and accounting system provides the financial information needed to effectively plan, control, and evaluate project activity, whether required by FmHA or not. The type of system should be determined prior to loan closing but may be revised with FmHA approval to meet program objectives. The Agency may also prescribe the system to be used. Form FmHA 1930-5, "Bookkeeping System—Small Borrower," can be adapted to the bookkeeping needs of small projects. Bookkeeping for MFH projects may be maintained using a cash, modified cash, or accrual type accounting system.

1. *Type of accounts.* As used in this paragraph, the term account is used interchangeably to mean either a ledger (or bookkeeping account) or an actual banking account, except for reserve accounts. Reserve accounts must be kept in a supervised bank account but may also be reflected in an appropriate ledger in the recordkeeping or accounting system. Depending upon the complexity of the accounting system being used, these accounts may be further subdivided into subsidiary ledgers or accounts to assist the borrower in providing the information needed for project financial analysis or reporting requirements. Regardless of the number or types of accounts established, all bookkeeping and accounting systems must meet the following:

a. All project funds shall be held only in domestic accounts. All project funds shall be held only in accounts insured by an agency of the Federal Government or backed by collateral provided by the bank.

b. All funds in any account shall be used only for authorized purposes as described in their loan agreement or resolution and this subpart.

c. All funds received and held in any account, except the security deposit, membership fee, and management reserve (patronage capital), shall be held in trust by the borrower for the loan obligation until used and serve as a security for the FmHA loan or grant.

d. All project funds will be accounted for by adequate and clear accounting methods and practices that otherwise maintain proprietary identity of said funds.

e. Each project will maintain at least one demand deposit or checking account, in addition to the supervised bank account for the reserve account. It is not necessary for each bookkeeping account within one project to be maintained as a checking account. However, a separate checking account may also be required for any tenant

security account to comply with local and State laws and regulations.

f. In no case shall project funds be pledged as collateral for non-FmHA debts.

2. *Accounts.* All RRH, RCH, and LH borrowers will maintain, as a minimum, the accounts required by their loan agreement or resolution. The following accounts are standard for all RRH and RCH loans approved after October 27, 1980, or those who have amended their previous loan agreements or resolutions to adopt these accounts, or those required by a servicing plan. The following listing of accounts also identifies the order of funding of each of the listed accounts through available project revenues each month

a. *General Operating Account.* This account records all project income and disbursements. Excess project cash held in this account may be combined with other project funds described in this paragraph in temporary (immediate call) interest bearing accounts when separate bookkeeping records are maintained for the individual project accounts. This account may be further subdivided as follows:

(1) *Initial Operating Capital.* The initial operating capital may be in the form of cash, an irrevocable letter of credit, or in a combination of the two as set forth in § 1944.211 (a)(6) of subpart E of part 1944 of this chapter. The borrower will have deposited the required initial operating cash into the General Operating Account by the time of the FmHA loan closing or when interim financing funds are obtained, whichever occurs first. These funds will blend with other revenue that accrues to the account to cover budgeted expenditures including payment of return to owner. Any letters of credit will be supplied by the time of the FmHA loan closing or when interim financing funds are obtained, whichever occurs first. Letters of Credit will be maintained in the casefile. They must be renewed as needed so that a current Letter of Credit is always in effect. If a borrower does not renew the Letter of Credit they will be required to deposit an equivalent amount of cash into the General Operating Account before the Letter of Credit expires. If a borrower supplied all or part of the initial operating capital in the form of a Letter of Credit and the borrower makes cash deposits into the General Operating Account for operating purposes, the borrower can provide the District Office with a new Letter of Credit in a smaller amount with evidence of the cash deposit. The new Letter of Credit and the cash deposit must total the required

initial operating capital. The old Letter of Credit will be returned to the borrower. After two, but before five full (12 month) borrower fiscal years of project operation, the borrower may request (in writing) the State Director's authorization to make a onetime withdrawal of the initial operating capital, or a part of it. The withdrawal can be in the form of cash, release or reduction in the Letter of Credit, or a combination of both. The one time withdrawal can never exceed the initial operating capital as described in the loan agreement or loan resolution. The withdrawal can be approved provided that:

(i) The project has achieved at least a 95 percent occupancy level at the time of the withdrawal;

(ii) The withdrawal will not affect the financial integrity of the project. After withdrawal, approximately 10 percent of the projected operation and maintenance expenses should remain in the general operating account in excess of current liabilities then outstanding. The reserve account must be on schedule less authorized withdrawals. The borrower must demonstrate that all prudent maintenance is being planned and performed, and payment of necessary project expenses are not being deferred;

(iii) The State Director determines that the withdrawal will not necessitate a rent increase during the year of withdrawal or during the next year of operation, except that rent increases needed because of normal increases of operation and maintenance expenses unrelated to the withdrawal may be approved; and

(iv) The State Director has reviewed and approved any required borrower reports before the initial operating capital is withdrawn. Promptness is expected but actual withdrawal of funds could occur in the sixth year.

(2) *Deposits.* All income and revenue from the housing project shall, upon receipt, be immediately deposited in the general operating account. This will include rent or occupancy charge receipts, housing subsidy payments (including HUD Section 8 and FmHA RA payments), occupancy surcharge monies, laundry revenue, or any other project income, including interest earned on project accounts. The borrower may also deposit other funds at any time, which are to be used for purposes authorized by this section, including transfers from the reserve account.

(3) *Disbursements.* Not later than the 15th of each month, out of the general operation account, the borrower shall pay or fund the actual, reasonable and necessary monthly project expenses.

Current expenses may include the initial purchase and installation of furnishings and equipment with any other funds deposited in the general operating account which are not proceeds of the loan or income or revenue from the project. (However, nonprofit borrowers are permitted to use loan funds specified for initial operating capital purposes as authorized in subparts D and E of part 1944 of this chapter.) Other authorized disbursements are FmHA approved installments of debt service, including occupancy surcharge, real estate tax and insurance escrow, reserve, and return on investment. Any balance remaining in an RRH general operating account except as authorized above, may be retained in this account or transferred to the reserve account. Any balance remaining in an RCH general operating account will be transferred into the cooperative's patronage capital account at the end of the fiscal year.

(4) *Unauthorized Disbursements.* Except for cooperatives, late fees charged the borrower according to subpart K of part 1951 of this chapter, may not be paid from project income. When late fees are deducted by FmHA from payments made from project income, the project general operating account must be reimbursed from nonproject income of the owner or management agent or deducted from the owner's return on investment.

b. *Real Estate Tax and Insurance Escrow Account.* According to the borrower's management plan, project funds for periodic payment(s) of real estate taxes and real property insurance may be deposited in a real estate tax and insurance escrow account or held in the general operating account as cash on hand. The escrow account may be an interest bearing account. Deposits to the account should be in monthly increments of one-twelfth of the annual anticipated real estate tax and insurance payments. Any interest earned shall accrue to the project as project operational cash income.

c. *Reserve Account.* The reserve account is a required account subject to the requirements set out in this section.

(1) The reserve account is primarily used to meet the major capital expenditure needs of a project. It is expected that the reserve account should rarely have to be used to meet any non-capital expenditure needs of a project; however, the District Director may approve such uses when warranted in unusual circumstances.

(2) Effective as of _____ (date)
_____ 60 DAYS AFTER THE
PUBLICATION OF THE FINAL RULE,
reserve accounts will be required to be placed in a supervised bank account.

The provisions set out in Subpart A of Part 1902 of this chapter will apply.

(3) The borrower will initiate monthly deposits in this project account, preferably an interest bearing account, starting the same month the first loan payment is due FmHA. As projects age, the required Reserve Account level may be adjusted to meet anticipated "Life-cycle" needs, including equipment and facility replacement costs, by amending the loan agreement/resolution. Reserve accounts shall be subject to the following:

(i) Immediately after paying each installment for the orderly retirement of the FmHA loan, as provided in the borrower's promissory note, required reserve installments shall be transferred to the reserve account at the monthly rate stipulated by the borrower's loan agreement or resolution. Monthly transfers will continue until the account reaches the total amount specified in the loan agreement or resolution. Monthly transfers shall be resumed the month following withdrawals that decrease the reserve account balance below its required level until it is restored to the specified total minimum sum.

(ii) Reserve account funds not immediately needed for authorized purposes may be invested in saving certificates issued by a Federal Agency or invested in readily marketable obligations of the United States Treasury Department; however, the borrower must demonstrate that such funds are still subject to the supervised bank account provisions set out in subpart A of part 1902 of this chapter.

(iii) The Agency encourages borrower's to establish interest bearing reserve accounts; however, the borrower may choose whether to deposit reserve account funds in an interest or non-interest bearing account. If reserve funds are deposited in an interest bearing account, the interest earnings may be used to meet the monthly installments to the reserve account and/or to meet a modified and higher reserve level established periodically by an FmHA approved amendment to the borrower's loan agreement or resolution. Such amendment may be made to build reserve for scheduled replacement of depreciable property items in addition to general reserve requirements.

(iv) The reserve account withdrawal and verification policies are set out in subpart A of part 1902 of this chapter. Any withdrawal from the reserve account should be recorded on a withdrawal format for tracking and reconciliation. Authorized purposes are:

(A) To meet payments due on the loan obligations in the event the amount for

debt service is not sufficient for that purpose.

(B) To pay costs of repairs or replacements to the housing, furnishings or equipment, or shortfalls of current expenses. Withdrawal for planned authorized purposes should be approved in advance during the annual budget approval process. Annual budgets will include realistic routine income and expense levels to minimize use of the reserve for routine expenses (operating deficits).

(C) To make improvements to the housing project without creating new living units or to retrofit units to make them accessible to the physically handicapped.

(D) For other purposes desired by the borrower, which in the judgment of the Government will promote the loan purposes, strengthen the security, or facilitate, improve, or maintain the orderly collection of the loan without jeopardizing the loan or impairing the adequacy of the security.

(E) To pay a return on investment at the end of the borrower's project operating year, provided that after such disbursements the amount in the reserve account will not be less than that required by the loan agreement or resolution to be accumulated by that time minus any authorized withdrawals, and the amount in the reserve account will likely not fall below that required to be accumulated during the next 12 months.

(1) In the case of borrowers operating on a limited profit basis, to pay a return on the borrower's initial investment as identified in the loan agreement or resolution.

(2) In the case of borrowers operating on a full profit basis, to pay an annual return as specified in the borrower's loan agreement or resolution.

(v) Any amount in the reserve account which exceeds the total sum specified in the loan agreement or resolution may be transferred to the general operating account for the authorized purposes only when it is agreed between the borrower and the FmHA to be in excess of the requirement, and there is a specified need for the excess funds. However, the District Director may direct the excess sum to be retained in the reserve account when determined necessary to protect the Government's security interest, including a "trust fund" to provide future tenant or member subsidy when the current subsidy agreement(s) expires.

(vi) Funds in the reserve account may be used for purposes in accordance with this subpart. The borrower will request withdrawal of reserve funds in a written or confirmed manner. The District

Director will provide written authorization, in a timely manner, to the borrower for any authorized withdrawal of funds by the use of a letter before the borrower actually withdraws any funds. Any conditions for approval will be indicated in the letter. The District Director may post-approve reimbursement of the emergency use of general operating account funds from the reserve account if they were used for authorized purposes, and their expenditure would have been approved had a request for approval been submitted prior to the expenditure. The borrower must provide documented evidence showing the actual amount and use of funds before the post-approval action.

(vii) The borrower and the FmHA may develop systems to record deposits and withdrawals in the reserve account and to perform reconciliation of the account to determine the correct account balance.

Dated: July 17, 1992.

La Verne Ausman,
Administrator, Farmers Home
Administration.

[FR Doc. 92-20814 Filed 8-31-92; 8:45 am]

BILLING CODE 3410-07-M

7 CFR Part 1944

RIN 0575-AA92

Housing Application Packaging Grants

AGENCY: Farmers Home Administration, USDA.

ACTION: Proposed rule.

SUMMARY: The Farmers Home Administration (FmHA) proposes to amend the Agency's policies and procedures governing the administration of Housing Application Packaging Grants (HAPG). This action is necessary to comply with the Cranston-Gonzalez Affordable Housing Act of 1990, which allows private and public nonprofit organizations to participate as grant recipients to package housing applications in targeted underserved areas and colonias. The agency's proposal will result in reimbursing qualified organizations for the costs of preparing application for housing under certain agency housing programs.

DATES: Comments must be received on or before November 2, 1992.

ADDRESSES: Submit written comments, in duplicate, to the Office of the Chief, Regulations Analysis and Control Branch, Farmers Home Administration, U.S. Department of Agriculture, room 6348, South Agricultural Building,

Washington, DC 20250. All written comments made pursuant to this notice will be available for public inspection during regular work hours at the above address.

FOR FURTHER INFORMATION CONTACT: Betsy McDaniel, Senior Loan Specialist, Single Family Housing, Farmers Home Administration, U.S. Department of Agriculture, room 5346, South Agriculture Building, 14th and Independence Avenue SW., Washington, DC 20250. Telephone: (202) 690-4209.

SUPPLEMENTARY INFORMATION: This proposed action has been reviewed under USDA procedures established in Departmental Regulation 1512-1 which implements Executive Order 12291, and has been determined to be nonmajor because there is no substantial change from practices under existing rules that would have an annual effect on the economy of \$100 million or more. There is no major increase in the cost or prices for consumers, individual industries, Federal, State, or local government agencies or geographical regions, or significant adverse effects on competition, employment, productivity, innovation, or in the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Discussion

Section 709 of the Cranston-Gonzalez National Affordable Housing Act provides for grants to public and private non-profit agencies to promote the development of affordable housing in designated counties and colonias. The designated counties are defined by the following criteria: (a) twenty percent or more of the population is at or below poverty level and (b) ten percent or more of the occupied housing units are substandard. These grants cannot exceed customary and reasonable costs of preparing an application for a loan under sections 502, 504, 514, 515, or 524, or a grant under section 533. Under Sections 514 and 515, a portion of the costs will come from loan funds as well as grant funds. Grant recipients will have to complete an application packaging training certification course given by FmHA each year in order to be qualified to submit application packages. Grantees will be reimbursed for the complete loan and grant packages submitted. State Directors will determine how many of each type of loan can be feasibly processed in each designated county. This number will be based on the State's allocation and staffing resources to process the loans

After sufficient packages are received, the State Director may stop the availability of HAPG funds in a particular county. FmHA will also make additional conforming amendments for other rules contained in 7 CFR at the final rule stage to reflect the addition of the program and any necessary changes.

Environmental Impact Statement

This document has been reviewed in accordance with 7 CFR part 1940, subpart G, "Environmental Program." It is the determination of FmHA that this action does not constitute a major Federal Action significantly affecting the quality of the human environment, and in accordance with the National Environmental Policy Act of 1969, Public Law 91-190, an Environmental Impact Statement is not required.

Regulatory Flexibility Act

In compliance with the Regulatory Flexibility Act (Public Law 96-354), the undersigned has determined and certified by signature of this document that this rule will not have a significant economic impact on a substantial number of small entities because it contains normal business recordkeeping requirements and minimal essential reporting requirements.

Paperwork Reduction Act

The collection of information requirements contained in this regulation have been submitted to the Office of Management and Budget for review under section 3504(h) of the Paperwork Reduction Act of 1980. Public reporting burden for this collection of information is estimated to average 3 hours per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Agriculture, Clearance Officer, OIRM, room 404-W, Washington, DC 20250; and to the Office of Management and Budget, Attention: Desk Officer for the Farmers Home Administration, Washington, DC 20503.

Civil Justice Reform

This document has been reviewed in accordance with Executive Order (E.O.) 12778. It is the determination of FmHA that this action does not unduly burden the Federal Court Systems in that it meets all applicable standards provided in section 2 of the E.O.

Programs Affected

The Catalog of Federal Domestic Assistance programs affected by this action are:

- 10.405 Farm Labor Housing Loans and Grants
- 10.410 Low-Income Housing Loans
- 10.411 Rural Housing Site Loans
- 10.415 Rural Rental Housing Loans
- 10.417 Very Low-Income Housing Repair Loans and Grants
- 10.433 Rural Housing Preservation Grants

Intergovernmental Consultation

For the reason set forth in the final rule and related Notice to 7 CFR part 3015, subpart V, 48 FR 29115, June 24, 1983, 10.410 Low-Income Housing Loans and 10.417 Very Low-Income Housing Repair Loans and Grants are excluded from the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials. All other programs affected by this program are included in this process.

List of Subjects in 7 CFR Part 1944

Administrative practice and procedure, Grant programs—Housing and community development, Loan programs—Housing and community development, Migrant labor, Nonprofit organizations, Reporting and recordkeeping requirements, Rural housing.

Therefore, as proposed, chapter XVIII, title 7, Code of Federal Regulations, is amended as follows:

PART 1944—HOUSING

1. The authority citation for part 1944 continues to read as follows:

Authority: 42 U.S.C. 1480; 5 U.S.C. 301; 7 CFR 2.23; 7 CFR 2.70.

Subpart B—Housing Application Packaging Grants

2. Subpart B of part 1944 is added to read as follows:

Subpart B—Housing Application Packaging Grants

- Sec.
- 1944.51 Objective.
- 1944.52 Definitions.
- 1944.53 Grantee eligibility.
- 1944.54–1944.61 [Reserved]
- 1944.62 Authorized representative of the applicant.
- 1944.63 Authorized use of grant funds.
- 1944.64–1944.65 [Reserved]
- 1944.66 Administrative requirements.
- 1944.67 Ineligible activities.
- 1944.68 [Reserved]
- 1944.69 FmHA point of contact.
- 1944.70 Targeting of HAPG funds to States.

Sec.

- 1944.71 Term of grant.
- 1944.72 Application packaging orientation.
- 1944.73 Application package submission.
- 1944.75 Exception authority.
- 1944.76–1944.100 [Reserved]
- Exhibit A—[Reserved]
- Exhibit B—Housing Application Packaging Grants (HAPG) Fee Processing
- Exhibit C—Requirements for Housing Application Packages
- Exhibit D—Designated Counties for Housing Application Packaging Grants

Subpart B—Housing Application Packaging Grants

§ 1944.51 Objective.

This subpart states the policies and procedures for making grants under section 509 of the Housing Act of 1949, as amended (42 U.S.C. 1479). Grants reimburse eligible organizations for part or all of the costs of conducting, administering, and coordinating an effective housing application packaging program in colonias and designated counties. Eligible organizations will aid very low- and low-income individuals and families in obtaining benefit from Federal, State, and local housing programs. The targeted groups are very low- and low-income families without adequate housing who will receive priority for recruitment and participation and nonprofit organizations able to propose rental or housing rehabilitation assistance benefiting such families. These funds are available only in the areas defined in Exhibit D of this subpart. Participants will assist very low- and low-income families in solving their housing needs. One way of assisting is to package single family housing applications for families wishing to buy, build, or repair houses for their own use. Another way is to package applications for organizations wishing to develop rental units for lower income families. The intent is to make Farmers Home Administration (FmHA) housing assistance programs available to very low- and low-income rural residents in colonias and designated counties. FmHA will reimburse eligible organizations packaging loan/grant applications without discrimination because of race, color, religion, sex, national origin, age, familial status, or handicap if such an organization has authority to contract.

§ 1944.52 Definitions.

References in this subpart to County District, State, National and Finance Offices, and to County Supervisor, District Director, State Director, and Administrator refer to FmHA offices and officials and should be read as prefaced

by FmHA. Terms used in this subpart have the following meanings:

Colonias. As defined in Exhibit C of subpart L of part 1940 of this chapter.

Complete application package (hereafter called *package*). The package submitted to the appropriate FmHA office which is considered acceptable in accordance with Exhibit C of this subpart.

Cost reimbursement. Amount determined by the Administrator that equals the customary and reasonable costs incurred in preparing an application package for a loan or grant. These amounts are included in Exhibit B of this subpart.

Designated counties. These counties are listed in Exhibit D of this subpart. Using the most recent published census data, the counties meet the following criteria:

- (1) Twenty percent or more of the county population is at or below the poverty level; and
- (2) Ten percent or more of the occupied housing units are substandard.

Organization. Any of the following entities which are legally authorized to work in designated counties and/or colonias and are:

- (1) A State, State agency, or unit of general local government; or
- (2) A private nonprofit organization or corporation that is owned and controlled by private persons or interests, is organized and operated for purposes other than making gains or profits for the corporation and is legally precluded from distributing any gains or profits to its members.

Packager. Any eligible organization which is reimbursed with Housing Application Packaging Grants (HAPG) funds.

Technical assistance. Any assistance necessary to carry out housing efforts by or for very low- and low-income individuals/families to improve the quality and/or quantity of housing available to meet their needs. Such assistance must include but is not limited to:

- (1) Contacting and assisting very low- and low-income families in need of adequate housing by:
 - (i) Implementing an organized outreach program using available media and personal contacts;
 - (ii) Explaining available housing programs and alternatives to increase the awareness of very low- and low-income families and to educate the community as to the benefits from improved housing;
 - (iii) Assisting very low- and low-income families in locating adequate housing; and

(iv) Developing and packaging loan/grant applications for new construction, and/or rehabilitation, or repair of existing housing.

(2) Contacting and assisting eligible applicants to develop Multi-Family Housing loan and/or grant applications for new construction, rehabilitation or repair to serve very low- and low-income families.

§ 1944.53 Grantee eligibility.

An eligible grantee is an organization as defined in § 1944.52 of this subpart and has received a current "Certificate of Training" pertaining to the type of application being packaged. In addition, the grantee must:

(a) Have the financial, legal and administrative capacity to carry out the responsibilities of packaging housing applications for very low- and low-income applicants. To meet this requirement it must have the necessary background and experience with proven ability to perform responsibly in the field of housing application packaging, low-income housing development, or other business or administrative ventures which indicate an ability to perform responsibly in this field of housing application packaging.

(b) Legally obligate itself to administer grant funds, provide adequate accounting of the expenditure of such funds, and comply with FmHA regulations.

(c) If the organization is a private nonprofit corporation, be a corporation that:

- (1) Is organized under State and local laws.
- (2) Is qualified under section 501(c)(3) of the Internal Revenue Code of 1986.
- (3) Has as one of its purposes assisting very low- and low-income families to obtain affordable housing.

§§ 1944.54-1944.61 [Reserved]

§ 1944.62 Authorized representative of the applicant.

FmHA will deal only with authorized representatives designated by the applicant. The authorized representatives must have no pecuniary interest in any of the following, as they would relate in any way to the HAPG: the award of any engineering, architectural, management, administration, or construction contracts; purchase of the furnishings, fixtures or equipment; or purchase and/or development of land.

§ 1944.63 Authorized use of grant funds.

Grant funds may only be used to reimburse a packager for delivered packages. Payment will be made for each complete package received and

accepted in accordance with Exhibit C of this subpart.

§§ 1944.64-1944.65 [Reserved]

§ 1944.66 Administrative requirements.

The following policies and regulations apply to grants made under this subpart:

(a) Grantees must comply with the nondiscrimination regulation, subpart E of part 1901 of this chapter, which states that no person in the United States shall, on the grounds of race, color, national origin, sex, religion, familial status, handicap, or age, be excluded from participating in, be denied the benefits of, or be subject to discrimination in connection with the use of grant funds and all provisions of the Fair Housing Act of 1988.

(b) The policies and regulations contained in subpart S of part 1940 of this chapter apply to grantees under this subpart.

(c) The policies and regulations contained in subpart Q of part 1940 of this chapter apply to grantees under this subpart.

(d) Grantees should be aware of the policies and regulations contained in subpart G of part 1940 of this chapter. They will supply needed information requested by the local FmHA office in connection with the loan or grant application.

(e) The grantee will retain records for three years from the date Standard Form (SF) 269A, "Financial Status Report (Short Form)" is submitted. These records will be accessible to FmHA and other Federal officials in accordance with 7 CFR part 3015.

(f) Annual audits will be completed if the grantee has received more than \$25,000 of Federal assistance in the year in which HAPG funds were received. These audits will be due 13 months after the end of the fiscal year in which funds were received.

(1) States, State agencies, or units of general local government will complete an audit in accordance with 7 CFR parts 3015 and 3016 and OMB Circular A-128.

(2) Nonprofit organizations will complete an audit in accordance with 7 CFR part 3015 and OMB Circular A-133.

(g) Performance reports, as required, will be submitted in accordance with 7 CFR part 3015.

§ 1944.67 Ineligible activities.

The packager may not charge fees or accept compensation or gratuities directly or indirectly from the very low- and low-income families being assisted under this program. The packager may not represent or be associated with anyone else, other than the applicant, who may benefit in any way in the

proposed transaction. If the packager is compensated for this service from other sources, then the packager is not eligible for compensation from this source except as permitted by FmHA. Grantees who are funded to do Self-Help Housing, may not be reimbursed for packaging applications for participation in the Self-Help Housing effort.

§ 1944.68 [Reserved]

§ 1944.69 FmHA point of contact.

Grantees must submit packages to the appropriate FmHA office serving the designated county and/or colonias. Packages for Single Family Housing loans and grants are submitted to the appropriate County Office. All other packages are submitted to the appropriate District Office. The applicable forms required to develop a complete application package can be obtained in any District or County Office. Packagers should coordinate their packaging activity with the appropriate District and County Offices.

§ 1944.70 Targeting of HAPG funds to States.

(a) HAPG funds will be distributed administratively by the Administrator to achieve the success of the program. Allocations will be distributed to States as set forth in Attachment 2 of exhibit A of subpart L of part 1940 of this chapter.

(b) The State Director will determine based on the housing funds available and the personnel available, how many applications can be processed for each program during the fiscal year in each FmHA office serving a designated county and/or colonias. The number of applications will be published in the advertisement required under § 1944.72 of this subpart.

§ 1944.71 Term of grant.

(a) For Single Family Housing loans and grants, HAPG funds will be specifically available for designated counties. Packages may be submitted after the annual housing application packaging training is held. The grant period will end when sufficient packages are received for each designated county or colonia or on September 30 of the fiscal year, whichever is earlier.

(b) For Multi-Family Housing loans and grants, HAPG funds will be available for designated areas or colonias to the extent specified in the State Director's public notice. Preapplications approved in one fiscal year, for which grant funds were obligated, may have the balance disbursed in a later fiscal year when the application is submitted and approved.

§ 1944.72 Application packaging orientation.

FmHA approval officials will orient and train organizations on how to package. A newspaper advertisement will be published by FmHA offices serving designated counties and/or colonias after October 1. The advertisement will announce that application packaging services are being requested and specify the date of the certification training. All eligible organizations may attend this training. This date will be no more than 30 days after the advertisement appears in the newspaper and no later than December 31 of any year. The announcement will include the estimated number of packages needed by loan type, i.e., single family, multi-family, etc. Exhibit A of this subpart (available in any FmHA office) is an example of an appropriate announcement. "Certificates of Training" as required under § 1944.53 of this subpart will be signed by the State Director and given after completion of the training. Efforts will be made by the appropriate FmHA office to complete this training process and certify packagers as quickly as possible. Grantees must attend this training each year in order to qualify for assistance.

§ 1944.73 Application package submission.

(a) When submitting their first complete application package to an FmHA office, in addition to the item in paragraph (b) of this section and the information set forth in Exhibit C of this subpart, the organization must submit the following. A file of these documents will be established in the FmHA office and retained in accordance with FmHA Instruction 2033-A (available in any FmHA office).

(1) Proof of their nonprofit status under section 501(c)(3) or section 501(c)(4) of the Internal Revenue Code of 1986 or of their existence as a State agency or unit of general local government legally authorized to work in the designated county and/or colonias. If the FmHA approval official is in doubt about the legal status of the organization, the evidence will be sent to the State Director. The State Director may, if needed, submit the above documents with any comments or questions to the Office of General Counsel for an opinion as to whether the applicant is a legal organization of the type required by these regulations.

(2) An original and copy of Form FmHA 400-1, "Equal Opportunity Agreement," and FmHA 400-4, "Assurance Agreement."

(3) A copy of a current "Certificate of Training" pertaining to the type of application package submitted.

(b) All packages must contain a signed statement which states, "Neither the organization nor any of its employees have charged, received or accepted compensation from any source other than FmHA for packaging this application and are not associated with or represent anyone other than the applicant in this transaction."

(c) An SF 270, "Request for Advance or Reimbursement" will be submitted with each application package for the amount authorized for the specific loan type in Exhibit B of this subpart.

(d) The FmHA approval official will review each application package for completeness, accuracy and conformance to program policy and regulations. Cost reimbursement will be made in accordance with Exhibit B of this subpart (available in any FmHA office). Packagers that submit incomplete packages for Sections 502 and 504 loans/grants will be sent a letter within 5 working days after submission of the package advising of additional information needed. Payment will be held until all the information is received.

(e) Submissions for sections 514, 515, and 524 loans and grants will be reviewed and, if incomplete, a letter sent within 15 working days advising of additional information required.

(f) An SF 269A will be submitted within 15 days of the end of the fiscal year.

§ 1944.74 Debarment or suspension.

Certified packagers whose actions or acts warrant they not be allowed to participate in the program are to be investigated in accordance with paragraph § 1940.606(c) of FmHA Instruction 1940-M (available in any FmHA office).

§ 1944.75 Exception authority.

The Administrator may, in individual cases, make an exception to any requirement or provision of this subpart which is not inconsistent with the authorizing statute or other applicable law if the Administrator determines that the Government's interest would be adversely affected. The Administrator will exercise this authority only at the request of the State Director and recommendation of the Assistant Administrator, Housing. Requests for exceptions must be in writing by the State Director and supported with documentation to explain the adverse affect on the Government's interest and/or impact on the applicant, borrower, or

community, proposed alternative course of action, and show how the adverse affect will be eliminated or minimized if the exception is granted.

§§ 1944.76-1944.100 [Reserved]

Exhibits to Subpart B

Exhibit A—[Reserved]

Exhibit B—Housing Application Packaging Grants (HAPG) Fee Processing

The Farmers Home Administration (FmHA) approval official will execute and distribute Form FmHA 1940-1, "Request for Obligation of Funds," in accordance with the Forms Manual Insert (FMI). HAPG funds will be used for the fees except as otherwise noted in sections 514 and 515. Funds for all loan and/or grant application packages will be paid as follows.

I. For all Single Family Housing loans, (Sections 502, 504, and 514 ("on farm" labor housing only) of the Housing Act of 1949) checks will be ordered when complete application packages as defined in § 1944.73 and Exhibit C of this subpart are received. The fees are as follows:

(A) Section 502 Single Family Housing Loans—\$300

(B) Section 504 Rural Housing Loans and Grants—\$300

(C) Section 514 On Farm Labor Housing Loans—\$300

II. For all multi-family housing loans and grants (Sections 514/516, 515, 524, and 533 of the Housing Act of 1949) the entire amount of the fee coming from HAPG funds will be obligated when the packager has met all the requirements of the preapplication stage, however, payments will be made in accordance with the following schedules:

(A) Sections 514/516 Farm Labor Housing Loans and Grants

"Off" Farm Labor Housing loans/grants—fees paid in accordance with the schedule for Section 515 Rural Rental Housing.

(B) Section 515 Rural Rental Housing Loans

(1) The scale for packaging fees is based on the percentage of the total development cost as follows:

Up to \$400,000: 1.6 percent.

For additional amounts between:

\$400,001 and \$800,000: add 1.2 percent.

\$800,001 and \$1,200,000: add 1.0 percent.

\$1,200,001 and \$1,600,000: add .7 percent.

\$1,600,001 and \$2,000,000: add .5 percent.

Over \$2,000,001: No additional amount.

(2) Twenty-five percent paid from HAPG funds when Form AD-622, "Notice of Preapplication Review Action," is sent inviting submission of a complete application.

(3) Twenty percent paid from HAPG funds when a complete application is filed including plans and specifications.

(4) The 55 percent balance paid when the loan is approved. Funds for this 55 percent will be drawn from loan funds in accordance with § 1944.212(j) of subpart E of part 1944 of this chapter for section 515 and § 1944.158(i) of subpart D of part 1944 of this chapter for section 514.

(C) Section 524 Rural Housing Site Loans

Total fee is 1 percent of the loan amount payable in two installments.

(1) Thirty percent paid after the State Director's review of the preapplication under paragraph XI, A of subpart G of part 1822 of this chapter (FmHA Instruction 444.8).

(2) Seventy percent paid upon the completion and submission of the docket in accordance with paragraph XI, C of subpart G of part 1822 (FmHA Instruction 444.8).

(D) Section 533 Housing Preservation Grants

Total fee is 2 percent of the grant amount paid in two installments.

(1) Forty percent will be paid when the Form AD-622, inviting submission of a complete application, is sent.

(2) Sixty percent will be paid after grant closes.

Exhibit C—Requirements for Housing Application Packages

I. A package will consist of the following requirements for the respective program.

A. Section 502—a complete application package will be submitted in accordance with the requirements of Exhibit A of subpart A of part 1944 of this chapter. The package must also include the following:

Form FmHA 410-9—"Statement Required by the Privacy Act."

Form FmHA 1910-11—"Applicant Certification, Federal Collection Policies for Consumer or Commercial Debts."

Form FmHA 1944-3—"Budget and/or Financial Statement."

B. Section 504—Complete application packages will be submitted in accordance with the requirements of Exhibit C of subpart J of part 1944 of this chapter. The package must include the forms listed in paragraph I. A. of this exhibit and the following:

Form FmHA 410-4—"Application for Rural Housing Assistance (Non-Farm Tract)."

Form FmHA 1910-5—"Request for Verification of Employment."

Form FmHA 1944-12—"Rural Housing Loan Application Package."

Evidence of ownership in accordance with § 1944.461(a) of subpart J of part 1944 of this chapter.

Cost estimates or bid prices for removal of health or safety hazards in accordance with § 1944.463(a) of subpart J of part 1944 of this chapter.

C. Section 514/516—Complete application packages will be submitted in accordance with Exhibit A-1 of subpart D of part 1944 of this chapter.

D. Section 515—Complete application packages will be submitted in accordance with the requirements of Exhibit A-7 of subpart E of part 1944 of this chapter.

E. Section 524—Complete application packages will be submitted in accordance with paragraph XI, A of subpart G of part 1822 of this chapter (FmHA Instruction 444.8). After Farmers Home Administration's review and as instructed, the application should be completed in accordance with paragraph XI, C of subpart G of part 1822 of this chapter (FmHA Instruction 444.8).

F. Section 533—Complete application packages will be submitted in accordance with the requirements of subpart N of part 1944 of this chapter.

Exhibit D—Designated Counties for Housing Application Packaging Grants

Alabama Counties (30)

Barbour	Lee
Bibb	Lowndes
Bullock	Macon
Butler	Marengo
Choctaw	Monroe
Clarke	Perry
Clay	Pickens
Conecuh	Pike
Coosa	Randolph
Crenshaw	Russell
Dallas	Sumter
Greene	Talladega
Hale	Tuscaloosa
Henry	Washington
Lawrence	Wilcox

Alaska (1)

Palmer

Arizona (2)

Apache Conconino

Arkansas (22)

Calhoun	Lafayette
Chicot	Lee
Columbia	Lincoln
Crittenden	Madison
Cross	Mississippi
Desha	Monroe
Jefferson	Nevada

Newton
Phillips
Scott
Searcy

St. Francis
Stone
Union
Woodruff

McCreary
Menifee
Monroe
Morgan
Owen
Owsley
Perry
Powell
Pulaski

Robertson
Rockcastle
Rowan
Russell
Washington
Wayne
Whitley
Wolfe

Rio Arriba
San Juan
San Miguel

Socorro
Taos
Torrance

Colorado (5)

Conejos
Costilla
Dolores

Huerfano
Saguache

Florida (11)

Franklin
Gadsden
Glades
Hamilton
Hardee
Hendry

Jackson
Jefferson
Liberty
Madison
Taylor

Georgia (68)

Appling
Atkinson
Baker
Brooks
Bulloch
Burke
Calhoun
Camden
Candler
Charlton
Clay
Clinch
Crisp
Decatur
Dodge
Dooley
Early
Echois
Emanuel
Evans
Gilmer
Glascock
Grady
Greene
Hancock
Irwin
Jasper
Jefferson
Jenkins
Johnson
Lanier
Laurens
Liberty
Macon

Marion
McDuffie
McIntosh
Meriwether
Miller
Mitchell
Montgomery
Morgan
Peach
Pulaski
Putnam
Quitman
Randolph
Schley
Screven
Seminole
Sumter
Talbot
Telfair
Terrell
Thomas
Toombs
Treutlen
Turner
Warren
Washington
Webster
Wheeler
Wilcox
Wilkes
Worth

Idaho (1)

Madison

Illinois (3)

Alexander
Pope

Pulaski

Kentucky (58)

Adair
Allen
Bath
Bell
Breathitt
Breckinridge
Butler
Carter
Casey
Christian
Clay
Clinton
Cumberland
Edmonson
Elliott
Estill
Fleming
Floyd
Garrard
Grayson

Green
Harlan
Hart
Henry
Jackson
Johnson
Knott
Knox
Larue
Laurel
Lawrence
Lee
Leslie
Letcher
Lewis
Lincoln
Madison
Magoffin
Marion
Martin

Acadia
Assumption
Avoyelles
Bienville
Catahoula
Clairborne
Concordia
De Soto
East Carroll
East Feliciana
Evangeline
Franklin
Iberville
Madison

Washington

Clearwater

Adams
Amite
Attala
Benton
Bolivar
Calhoun
Carroll
Chickasaw
Choctaw
Clairborne
Clarke
Clay
Coshoma
Covington
Franklin
Greene
Grenada
Holmes
Humphreys
Issaquena
Jasper
Jefferson
Jefferson Davis
Kemper
Lafayette
Lauderdale
Leake
Leflore
Lincoln

Bollinger
Carter
Douglas
Mercer
New Madrid
Oregon
Ozark
Pemiscot

Big Horn
Blaine

Catron
Dona Ana
Guadalupe

Louisiana (26)

Morehouse
Natchitoches
Pointe
Coupee
Red River
Richland
Sabine
St. Helena
St. Landry
Tangipahoa
Tensas
Union
West Feliciana

Maine (1)

Minnesota (2)

Mahnomen

Mississippi (59)

Lowndes
Madison
Marion
Marshall
Monroe
Montgomery
Neshoba
Newton
Noxubee
Oktibbeha
Panola
Perry
Pike
Quitman
Scott
Sharkey
Simpson
Smith
Sunflower
Tallahatchie
Tate
Tunica
Walthall
Washington
Wayne
Wilkinson
Winston
Yalobusha
Yazoo

Missouri (15)

Reynolds
Ripley
Scotland
Shannon
Texas
Washington
Wayne

Montana (4)

Glacier
Petroleum

New Mexico (12)

Luna
McKinley
Mora

Ashe
Beaufort
Bertie
Bladen
Chowan
Columbus
Duplin
Edgecombe
Franklin
Greene
Halifax
Hertford
Hoke
Hyde

Benson
Rolette

Adams

Adair
Atoka
Choctaw
McCurain

Adjuntas
Aguadilla
Barranquitas
Bayamon
Caguas
Camuy
Ciales
Coamo
Corozal
Fajardo
Guayama
Humacao

Allendale
Bamberg
Calhoun
Clarendon
Colleton
Darlington
Dillon
Edgefield
Fairfield

Bennett
Buffalo
Charles Mix
Corson
Dewey
Faulk

Bledsoe
Campbell
Claiborne
Clay
Cocke
Crockett
Cumberland
DeKalb
Fayette
Fentress
Grainger
Grundy
Hancock
Hardeman

North Carolina (28)

Jones
Madison
Martin
Northampton
Pender
Perquimans
Pitt
Robeson
Sampson
Tyrrell
Vance
Warren
Washington
Yancey

North Dakota (3)

Sioux

Ohio (2)

Pike

Oklahoma (7)

Okfuskee
Pushmataha
Sequoyah

Puerto Rico (23)

Jayuya
Juana Diaz
Lares
Mayaguez
Morovis
Rio Grande
San German
San Lorenzo
San Sebastian
Utuado
Yauco

South Carolina (29)

Florence
Georgetown
Hampton
Jasper
Lee
Marion
Marlboro
Sumter
Williamsburg

South Dakota (11)

Jackson
Mellette
Shannon
Todd
Ziebach

Tennessee (28)

Hardin
Haywood
Jackson
Johnson
Lake
Lauderdale
Lewis
Morgan
Overton
Pickett
Scott
Sequatchie
Tipton
Union

Texas (58)

Atascosa	Jim Wells
Bailey	Kamea
Bee	Kenedy
Brooks	Kinney
Caldwell	Kleberg
Cameron	La Salle
Castro	Leon
Cochran	Lynn
Crosby	Madison
Dawson	Marion
De Witt	Maverick
Dickens	Medina
Dimmit	Menard
Duval	Newton
Edwards	Palmer
El Paso	Presidio
Falls	Real
Floyd	Reeves
Frio	Robertson
Gaines	San Augustine
Glasscock	San Jacinto
Gonzales	Starr
Grimes	Terry
Hale	Uvalde
Hidalgo	Walker
Houston	Webb
Hudspeth	Willacy
Jeff Davis	Zapata
Jim Hogg	Zavala

Utah (2)

San Juan	Wayne
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Virginia (12)

Accomack	Lee
Brunswick	Mecklenburg
Charlotte	Northampton
Cumberland	Scott
Franklin	Southampton
Greensville	Surry

West Virginia (11)

Doddridge	Mingo
Gilmer	Monroe
Grant	Pendleton
Hardy	Summers
Lincoln	Webster
McDowell	

Dated: July 21, 1992.

La Verne Ausman,

Administrator, Farmers Home
Administration.

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BILLING CODE 3410-07-M

and various other statutes. The Board periodically reviews these procedures in an attempt to reduce burden associated with these procedures and to ensure that these processes function as efficiently as possible consistent with statutory requirements. As a result of this review, on August 12, 1992, the Board approved several proposals to change certain applications procedures to improve efficiency and reduce regulatory burden in the applications process. These changes include establishing certain procedures to limit extension of the pre-acceptance period for applications; offering prospective applicants the opportunity to submit a pre-filing notice of intent to file an application; eliminating the stock redemption notice requirement for bank holding companies that are and, following the redemption would remain, "well capitalized" on a consolidated basis and in generally satisfactory condition; expanding the authority of Reserve Banks to process all delegable applications without Board staff review; modifying the Board's delegation rules pertaining to competition and market concentration; reducing redundant post-acceptance processing of Board action cases; increasing the monitoring of cases requiring extended processing; and inviting public comment on a proposal to establish a general consent procedure under section 24A of the Federal Reserve Act for investments by state member banks in bank premises.

In addition to taking these steps, the Board invites public comment on any other ways in which the burden on applicants associated with the various application and notice procedures in the Board's regulations may be reduced, consistent with the Board's responsibilities and obligations under the relevant statutes.

DATES: Comments must be received by October 28, 1992.

ADDRESSES: Comments, which should refer to Docket No. R-0773, may be mailed to the Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue, NW., Washington, DC 20551, to the attention of Mr. William W. Wiles, Secretary; or delivered to the Board's Mail Room between 8:45 a.m. and 5:15 p.m., or to the Board's Security Control Room outside of those hours. Both the Mail Room and the Security Control Room are accessible from the courtyard entrance of 20th Street between Constitution Avenue and C Street, NW. Comments may be inspected in room B-1122 between 9 a.m. and 5 p.m. weekdays, except as provided in § 261.8 of the

Board's Rules Regarding Availability of Information, 12 CFR 261.8.

FOR FURTHER INFORMATION CONTACT:

Scott G. Alvarez, Associate General Counsel (202/452-3583), Robert D. Frierson, Managing Senior Counsel (202/452-3711), or Terence F. Browne, Attorney (202/452-3707), Legal Division; or Sidney M. Sussan, Assistant Director (202/452-2638), Beverly Evans, Supervisory Financial Analyst (202/452-2573), or Nicholas A. Kalambokidis, Supervisory Financial Analyst (202/452-3830), Division of Banking Supervision and Regulation, Board of Governors of the Federal Reserve System. For the hearing impaired *only*, Telecommunications Device for the Deaf (TDD), Dorothea Thompson (202/452-3544), Board of Governors of the Federal Reserve System, 20th and C Streets, NW., Washington, DC 20551.

SUPPLEMENTARY INFORMATION: The Federal Reserve System (System), has taken a number of significant steps over the past two decades to improve the overall efficiency of its processing of applications. The Board has recently reviewed its applications procedures again, and has taken a number of additional steps, described below, to reduce the burden associated with these procedures. The Board will implement the changes described in this notice immediately.

In addition, the Board invites comment on any additional steps the Board may take to improve the efficiency and increase the effectiveness of the applications process. In particular, the Board invites public comment on any other steps that the Board should consider for revising or streamlining the applications and notice procedures under the Board's rules to reduce the burden on applicants of these procedures without impairing the Board's ability to fulfil its statutory obligations in reviewing these proposals.

Explanation of Board Actions to Date to Reduce Regulatory Burden*Overview of Applications Processing*

The System has, for the past 15 years, met the Board's publicly articulated goal of processing 90 percent or more of System-wide applications within a self-imposed processing deadline (currently, 60 days from acceptance). During that time, more than 35,000 applications and notices have been processed, including approximately 10,000 nonbanking activity applications and notices, approximately 8,300 bank holding company formation applications, and 5,800 bank acquisition applications. The number of applications and notices

FEDERAL RESERVE SYSTEM**12 CFR Parts 208 and 225**

[Regulations H and Y; Docket No. R-0773]

Applications Under Regulation H and Regulation Y**AGENCY:** Board of Governors of the Federal Reserve System.**ACTION:** Notice of proposed rulemaking.

SUMMARY: The Board's Regulation H and Regulation Y establish procedures and provide guidance for obtaining Board approval for various transactions that are subject to Board review under the Federal Reserve Act, the Bank Holding Company Act, the Bank Merger Act, the Change in Bank Control Act

processed each year increased during the late 1970s and early 1980s to a peak of approximately 3,000 in 1983. Annual volumes declined in the mid 1980s, but then increased back up to the 3,000 level in 1991.

Over the past several years, approximately 14 percent of applications were processed for Board action, 52 percent were processed under delegated authority with Board staff review, and the remaining 34 percent were processed under delegated authority without Board staff review. The average post-acceptance processing time per application generally has declined to a low of 33 days in 1991. The average processing time for delegated cases has been significantly below the average processing time of the typically more complex Board action cases. In 1991, the average processing time for delegated cases was 28 days, compared to 50 days for Board action cases.¹ In comparison, in 1986 the average post-acceptance processing time per application was 30 days; the average processing time was 32 days for delegated cases and 71 days for Board action cases.

Based on its experience in reviewing proposals under the Federal banking laws, the Board has made a number of revisions to the applications process designed to improve the efficiency of the process and reduce burdens on interested parties to the process. Reserve Banks have been delegated substantial authority; application forms have been streamlined consistent with the Paperwork Reduction Act; unnecessary application procedures have been eliminated and notice procedures have been substituted for applications where appropriate under the statutory framework; information requirements for certain activities have been reduced; Board standards and policies have been more widely disseminated; internal time guidelines for reviewing and acting on proposals have been voluntarily imposed by regulation, and, after experience, substantially shortened. These efforts have resulted in the ability of the System to process more quickly a large number of increasingly complex applications with staffing levels that have remained relatively constant.

On April 22, 1992, as part of a broad review of the Board's regulations, policies, and reports, the Board requested that staff conduct a review of

various aspects of the applications process. This review has resulted in several final and proposed changes to the Board's applications rules. For example, the Board determined to substantially lessen the information required of a state member bank—in satisfactory conditions and with satisfactory community reinvestment and consumer compliance ratings—applying to establish additional branches. In an effort to facilitate acquisitions by nonbank subsidiaries of bank holding companies, the Board also revised Regulation Y to increase the applicability of its expedited applications procedure for small nonbank acquisitions. This revision, which became effective on June 29, 1992, increased the size of acquisitions that could be made after expedited procedures from a maximum of \$15 million to a maximum of the lesser of \$100 million or 5 percent of the applicant's consolidated assets, subject to certain criteria. The Board also increased the relative size of nonbank assets (from 20% to 50%) that may be acquired by a bank holding company in the ordinary course of business without any prior System approval, and established criteria for determining whether an application under the Bank Holding Company Act may be waived for transactions involving certain bank mergers.²

As a result of this review, the Board also requested comment on other proposals to reduce regulatory burden. In particular, on June 29, 1992, the Board published for comment proposed regulatory amendments that would reduce from twice to once the number of times notice must be published in a newspaper of general circulation of the filing, with the Board, of certain applications under the Federal Reserve Act and the Bank Holding Company Act.³ These amendments, intended to reduce the burden associated with the Board's notice requirements, would have no effect on the length or timing of public comment periods, which currently start when the first notice is published. At the same time, the Board also published for comment a proposed rule that would exempt from the limitations of section 23A of the Federal Reserve Act the transfer of assets and liabilities between affiliated insured depository institutions when such transfer is part of the merger or consolidation of the affiliated institutions.⁴ This proposed

exemption would be available for transactions requiring the approval of the resulting insured depository's primary regulator under the Bank Merger Act.

As part of the April review, the Board also directed staff to analyze the extent of the information being required in applications, timing considerations and procedures for pre-acceptance review and post-acceptance analysis of applications, standardization of application forms, and procedures for Board monitoring of the status of cases that exceed internal processing guidelines. This analysis had two primary objectives:

(1) To determine whether applications are being processed as efficiently as possible; and

(2) To identify opportunities to increase efficiency and/or reduce regulatory burden on the banking industry without jeopardizing important public policy objectives or the Board's ability to fulfill specific statutory objectives. This review was particularly focused on issues affecting processing time and duplication of effort, and this review resulted in several additional changes to certain applications procedures to improve efficiency, eliminate redundancy and otherwise reduce regulatory burden in the applications process.

Based on the Board's review, the Board has decided to take the following steps.

Change No. 1: Implementation of Certain Procedures to Limit Extension of the Pre-Acceptance Period for Applications

The goal of the pre-acceptance review is to assure that a reasonably complete record on which to base an analysis and supportable action has been established at the inception of the formal processing period. The review is generally conducted by Reserve Bank staff although Board staff, usually at the request of the Reserve Bank, also may participate in pre-acceptance review.

There is a common perception that pre-acceptance processing has resulted in unnecessary delays in the processing of applications. This perception is largely a result of certain conflicting considerations that often exist during the pre-acceptance period. The applicant often elects, or is required, to publicly announce a transaction soon after an agreement which circumscribes the transaction has been reached. From the applicant's perspective, this announcement may signal the beginning of the "processing period", yet the actual submission of the application

¹ In 1991, the average processing time for domestic delegated cases that required Board staff review was 29 days, compared to 25 days for domestic delegated cases not requiring Board staff review.

² 57 FR 28777, June 29, 1992.

³ 57 FR 28807, June 29, 1992.

⁴ 57 FR 28808, June 29, 1992.

may not occur for several weeks or even months after the announcement. To a large extent, both the timing and the quality of a submission are within the applicant's control, regardless of efforts the System may make to facilitate the process. Board and Reserve Bank staff, faced with the responsibility of completing processing under a tight time schedule, understandably are reluctant to accept a submitted application until most of the factors requiring the Board's consideration are addressed.

The System has taken a number of steps through the years to attempt to address applicants' concerns with the pre-acceptance process. These efforts include a willingness to accept and review draft applications, periodic reviews and modifications of the application forms, and an "open-door policy" permitting prospective applicants to discuss informally their proposals with Board or Reserve Bank staff.

In an attempt to monitor the timing of pre-acceptance activities, the System has adhered to formal timing guidelines in pre-processing most applications. If an applicant chooses to submit an application in draft, the draft application is to be reviewed for no more than 10 business days, with up to 3 additional business days for complicated applications. At the end of this period, the Reserve Bank must return the application to the applicant with comments. Once a formal application is received, the Reserve Bank has no more than 10 business days to either accept the application for processing, return the application to the applicant as materially deficient, or request additional information from the applicant. If more information is requested, the applicant has 8 business days in which to respond, after which the Reserve Bank has up to 5 business days to review the submission. At this point, the Reserve Bank must either accept the application for processing (under either delegated authority or for Board action) or return it.⁵

The pre-acceptance timing guidelines were last tightened in 1983 from a 13-10-6-day standard to the current 10-8-5-day standard. Given weekends and holidays, the current pre-acceptance process can take up to approximately 34 calendar days to complete if each step requires the maximum number of days.

When organizations are contemplating a large acquisition or a sophisticated proposal, the Reserve Banks often have encouraged the

applicant to file a draft application. The Reserve Banks believe that the filing of a draft application in these cases helps both the System and the applicant identify and address potential issues early in the process. Although the filing of a draft application may result in fewer questions being asked during the official pre-acceptance process, such filing may extend the total application processing period.

The Board always has considered draft applications to be an option available to an applicant, but the Board's rules do not require the filing of a draft under any circumstance. In this regard, the Board emphasizes that draft applications are not required for any proposals, and may be filed when an applicant determines in its discretion to do so.

There have been cases in which Reserve Banks have not returned an incomplete application at the end of the pre-acceptance process, and instead have accepted the application after expiration of the time provided in the Board's regulations governing the pre-acceptance process. The Reserve Banks have taken this step generally in an effort to reduce the applicant's burden of refiling the application.

When the Board implemented its regulations establishing a pre-acceptance schedule, the Board indicated that it intended the Reserve Banks to abide by this schedule and to return incomplete applications at the end of the period. The Board has determined to increase monitoring efforts to ensure that the Reserve Banks abide by the pre-acceptance schedule. To address the possibility that an applicant may be able to complete an application if given a brief extension of the pre-acceptance process, the Board believes that an extension of the pre-acceptance review period should be permitted only where the applicant files a written request for such an extension.

Change No. 2: Offering Prospective Applicants the Opportunity to Submit a Pre-Filing Notice of Intent to File an Application

The information used in processing an application comes from four sources: the applicant, the System, other state and federal agencies, and the public. Each application form is intended to enable the System to gather essential information needed to make a reasoned judgment about the proposal. The formal questions in the application form are not intended to limit the applicant's presentation, but are designed to provide a sufficient record in a majority of cases if answered fully and appropriately. The applicant bears the

burden of presenting and documenting a case to meet the statutory criteria for approval, and is invited to submit any additional information that may support its proposal.

All applicants use the same application form for the same type of transaction regardless of the condition of the applicant or differences in the structure of the transaction. For example, bank holding company applications to acquire additional banks are filed on a given application form, and all applications to engage in nonbanking activities are filed on another form.

The application forms contain sunset dates and are reviewed and updated periodically through the System review process. The information requested in these forms has been streamlined significantly over the past several years in an attempt to limit requests for extraneous information, less frequently needed information, and information that is otherwise readily available to the System.

At the same time, however, there is some evidence that an applicant's initial submission is becoming, on average, less adequate because of a general increase in the complexity of proposed transactions and because of a lack of focus on emerging critical issues. As a result, a growing volume of information is being requested during Reserve Bank pre-acceptance processing and post-acceptance communications between both Board and Reserve Bank staff and the applicant. Although the reasons for additional information being requested varies, common reasons include:

- Application forms are not designed to request information on issues that may be unique to a particular proposal or that involve certain issues that may vary by proposal but are, nonetheless, significant, such as information regarding CRA performance and programs, risk assessment involving various complex activities, employment agreements, and commitment requirements for proposed nonbanking activities;
 - Required follow-up on developments at subsidiaries in less than satisfactory condition or with sub-par CRA performance; and
 - Information necessitated by comments or protests on a proposal.
- Applicants occasionally provide more information than is needed by the System to process a given application. In some of these cases, the applicant is endeavoring to anticipate possible future questions; in general, however, the additional information is comprised of readily available information.

⁵ Current procedures do not provide for a second request for information during pre-acceptance processing.

In some cases, time and expense can be avoided if the applicant is provided with early feedback on a proposal. Although the draft application is intended to serve as a vehicle for early feedback, in some cases, a pre-filing notice should more effectively achieve the same goals and be less burdensome to the applicant. The submission of a pre-filing notice is entirely voluntary. It would not detract from the applicant's opportunity to file a draft application, although the Board believes that the notice could diminish the need for a draft application.

The pre-filing notice should contain little more than a description of the proposal, and may be communicated to the Reserve Banks in writing or at a face-to-face meeting. After a brief review of the proposal, the Reserve Bank will then discuss with the prospective applicant what, if any, unusual or particular information beyond what is requested in the application form will likely be needed to process the application. This should enable the applicant to better focus on the issues in an application that are likely to be of greatest concern. Accordingly, the Board has determined to offer to prospective applicants the opportunity to submit a pre-filing notice of intent to file an application.

Change No. 3: Elimination of the Stock Redemption Notice Requirement for Bank Holding Companies That are and, Following the Redemption, Would Remain "Well Capitalized" on a Consolidated Basis and in Generally Satisfactory Condition

Bank holding companies currently are required under Regulation Y to submit a written notice before purchasing or redeeming their equity securities if the gross consideration for the purchase or redemption, when aggregated with the net consideration paid by the company for all such purchases or redemptions during the preceding 12 months, is equal to 10 percent or more of the company's consolidated net worth.⁸ This notice requirement is a prudential requirement imposed by the Board to monitor the capital levels of bank holding companies, and is not a statutory requirement.

The Board has determined that a bank holding company that is and will continue to be "well capitalized" and in generally satisfactory condition should not be required to file this notice prior to the redemption of its stock. The Board believes that the elimination of this notice requirement for companies that

meet the criteria noted above would not compromise safety and soundness concerns.

Change No. 4: Expansion of the Authority of Reserve Banks to Process All Delegable Applications Without Board Staff Review

Upon accepting an application, the System currently has four basic procedures for processing the application:

(1) *Board Action ("Nondelegated action")*—Applications analyzed by both Reserve Bank and Board staff, and presented to the Board for action, normally within a 60-day time frame.

(2) *Delegated Action with Prior Board Staff Review*—Applications analyzed by both Reserve Bank and Board staff, and approved by the Reserve Bank, normally within a 30-day time frame if no delegation criterion is violated.

(3) *Delegated Action without Prior Board Staff Review*—Applications analyzed only by Reserve Bank staff, and approved by the Reserve Bank, normally within a 30-day time frame.

(4) *Delegated Action for Small Nonbank Activities*—Applications involving certain small 4(c)(8) proposals analyzed by Reserve Bank staff, and approved with prior review by Board staff, normally within a 15-day time frame.

The criteria for processing applications under delegated authority are enumerated in the Board's Rules Regarding Delegation of Authority,⁷ and allow for Reserve Bank approval unless one or more of the following conditions is present:

- (i) A member of the Board has indicated an objection prior to the Reserve Bank's action;
- (ii) The Board has indicated that such delegated authority shall not be exercised by the Reserve Bank in whole or in part;
- (iii) A written substantive objection to the application has been properly made;
- (iv) The application raises a significant policy issue or legal question on which the Board has not established its position;
- (v) With respect to BHC formations, bank acquisitions or mergers, the proposed transaction involves two or more banking organizations;

⁷ 12 CFR part 265. The Board recently amended its delegation rules to eliminate certain numerical criteria that restricted a Reserve Bank's authority to act on applications involving: (a) Banking organizations that rank among a state's five largest banking organizations or among the 50 largest banking organizations in the United States; and (b) the acquisition of certain large nonbanking companies by bank holding companies with over \$1 billion in assets.

(A) That upon consummation of the proposal, would control over 30 percent of total deposits in banking offices in the relevant geographic market, or would result in an increase of at least 200 points in the Herfindahl-Hirschman Index (HHI) in a highly concentrated market (a market with a post-merger HHI of at least 1800); or

(B) Where divestitures designed to address any substantive anticompetitive effects are not effected on or before consummation of the proposed transaction;

(vi) With respect to nonbank acquisitions, the nonbanking activities involved do not clearly fall within activities that the Board has designated as permissible for bank holding companies under § 225.25(b) of Regulation Y.

As explained above, a subset of applications delegated to Reserve Banks currently may be approved without prior Board staff review. In 1991, 1,034 cases, or 34 percent of all applications processed by the System, were approved under delegated authority without Board staff review. In general, these cases must be "non-complex" and satisfy certain well-established financial and competitive criteria. These criteria were last revised at the end of 1990, at which time the range of proposals eligible for Reserve Bank approval without prior Board staff review was expanded. At the same time, the types of applications that could be processed without Board staff review also was expanded to include applications involving capital note requests, certain investments in bank premises, state member bank mergers involving unaffiliated banks, state bank memberships, change in bank control notifications, and director interlocks under the Management Interlock Revision Act of 1988.

Although each of the three delegated procedures described above allow for Reserve Bank approval, only the second category allows for Reserve Bank approval without concurrent Board staff involvement. In delegated cases that are subject to prior Board staff review, Board and Reserve Bank staff both analyze and review the case, although memoranda are not prepared for the Board because approval authority has been delegated to the Reserve Bank. In delegated cases that are not subject to prior Board staff review, all analysis and review is conducted at the Reserve Bank.

The internal timing guidelines for post-acceptance processing of delegated and Board action cases were last adjusted in 1983. The processing

⁸ 12 CFR 225.4(b).

schedule for delegated cases was shortened from 45 days to 30 days and the processing schedule for Board action cases was reduced from 90 days to 60 days.

As discussed above, Reserve Banks over the years have been given greater responsibility in processing applications. Reserve Banks also have been given the authority to process a larger variety of increasingly complex activities and proposals. The Board has determined to broaden the Reserve Banks' responsibilities further by giving the Reserve Banks the authority to process all delegable cases without Board staff review. According to the System's processing trends over the past few years, this change could eliminate the duplication of efforts by the Board and Reserve Bank staffs on approximately half of the total applications and notices processed by the System.

Although the Board believes that some improvement in average processing times will result from streamlining the processing of delegated applications, the Board believes there are two more important benefits that will result. First, a reduction in Board staff involvement should permit closer alignment of Reserve Bank authority with responsibility and should facilitate increased objectivity in measuring performance. Second, streamlining of delegated cases should permit more effective allocation of Board staff resources to work on the larger and more complicated cases that go to the Board, resulting in more efficient and timely processing of these cases. In addition, the Board believes that this change will enable Board staff to more effectively assist with pre-acceptance reviews of cases that are likely to be accepted for Board action, which should facilitate earlier identification of issues and result in fewer post-acceptance requests for information.

Because this change does not expand the types of cases that are delegable, the Reserve Banks essentially will be processing cases in which they have had prior experience. The Board's views on specific policy issues and legal questions which may affect the determination to delegate a case will continue to be communicated to the Reserve Banks through monthly conference calls, periodic meetings and conferences, Supervision and Regulation (SR) letters, and distribution of case memoranda and Board Orders. To ensure that the System's policies and procedures are being applied consistently across the System, Board staff will continue to monitor processing

of applications through operational reviews of Reserve Banks, after-the-fact reviews of selected case files, SR letters, conference calls, and System meetings. In addition, Reserve Bank staffs will be expected to continue to consult with Board staff on issues and problems as they arise.

Change No. 5: Modification of the Board's Delegation Rules Pertaining to Competition and Market Concentration

Recent experience indicates that applications not meeting the Board's rules for delegation solely because the combined market share of the merging firms is slightly over 30 percent generally do not raise competitive concerns. Furthermore, in many applications the increase in the HHI is well under 200. For example, an application representing the combination of banks with respective markets shares of 30 percent and 1 percent would result in an increase in the HHI of only 60 points, but would not be a delegable case.⁸ Consequently, the Board has determined to increase the market share criterion from 30 percent to 35 percent. Although it is difficult to specify the exact level at which a proposed merger would be viewed as an antitrust violation based on the resulting market share, the Board believes that 35 percent would be a reasonable level and would conform with the Justice Department's treatment of market concentration.⁹

The Board also has determined to modify the delegated processing criterion that an applicant proposing divestitures to meet competitive concerns must complete the divestiture on or before consummation of the proposed transaction. The Board has established its position on the timing of divestitures in several recent Board Orders.¹⁰ The Board has stipulated that

⁸ The increase in the HHI is calculated by multiplying the product of the respective market shares of the institutions involved in the transaction by 2. In other words, the increase in the HHI is determined by the formula $2xy$, where x and y represent the respective market shares of the merging firms.

⁹ The Department of Justice guidelines include what is called a leading firm proviso under which the department is likely to challenge the acquisition by the leading firm in a market of any firm that has a market share of 1 percent or more. The Department of Justice considers a company to be a leading firm if it has a market share of at least 35 percent and this share is approximately twice as large as that of the second largest firm.

¹⁰ See e.g., *BankAmerica Corporation*, 78 Federal Reserve Bulletin 338, 340 n.15 (1992).

applicants may be given up to six months after consummation to complete a divestiture provided that, prior to consummation, the applicant has entered into a binding agreement with another party to acquire the relevant offices. If the divestiture is not accomplished within this time frame, the branches to be divested must be placed with an independent trustee for immediate sale. The Board has determined to modify its criterion for delegated action to reflect this position on competitive divestitures.

With these two changes, the Board's fifth delegation limitation would read as follows:

(v) With respect to bank holding company formations, bank acquisitions or mergers, the proposed transaction involves two or more banking organizations that, upon consummation of the proposal, would control over 35 percent of total deposits (includes 50 percent of thrift deposits) in banking offices in the relevant geographic market, or would result in an increase of at least 200 points in the Herfindahl-Hirschman Index (HHI) in a highly concentrated market (a market with a post-merger HHI of at least 1800).

Change No. 6: Reduction of Redundant Post-Acceptance Processing of Board Action Cases

In processing Board action cases, both the Reserve Bank and Board staff analyze the proposal, recommend action, and prepare memoranda for the Board. The memoranda often are redundant and because the Reserve Bank must prepare its memorandum prior to completion of Board staff memoranda, the Reserve Bank memorandum may contain information that is not as current as the information in Board staff memoranda. In addition, communications between the applicant and the System are occasionally duplicated.

The Board has determined to give the Reserve Banks more discretion to determine the extent of their involvement in the post-acceptance analysis and memoranda writing on Board action cases. The Reserve Banks will continue to receive applications and perform pre-acceptance analysis on all applications. For applications accepted for Board action processing, the Reserve Banks generally will determine the extent of their subsequent involvement. The Board expects that Board staff will request the Reserve Banks to provide analysis for some cases in the same manner that the Reserve Banks currently analyze cases. In other cases, however, the Reserve Banks may elect

not to participate in post-acceptance analysis or to participate to a limited extent in a more focused manner.

This change will preserve the Reserve Bank's opportunity to present its views on an application or on an issue raised by a particular proposal, and should, in the case of requested comments, provide further support for the record in cases where the Reserve Bank's knowledge of local conditions would be especially beneficial. For example, Reserve Bank involvement can be an essential element in the timely resolution of protested issues.

In addition to the efficiency benefits of reducing duplicative processing in general, and memoranda writing in particular, this change also will give the Reserve Banks greater flexibility in allocating their resources. For example, resources that are currently devoted to the post-acceptance processing of certain Board action cases could be shifted to time sensitive delegated cases or to pre-acceptance meetings with prospective applicants.

Change No. 7: Increased Monitoring of Cases That Require Extended Processing

As part of the System's current overall process of monitoring applications activity, closer scrutiny is given to cases that are not on schedule for timely processing or have exceeded targeted action dates. Once a week, managers responsible for applications processing from the appropriate Board divisions (or their representatives), meet to discuss each application that is scheduled for Board action as well as other applications of interest. Previously delegated cases that have not been acted on within 30 days also are discussed at these meetings, as these cases usually have already been transferred to Board action status. The basis for this discussion is a weekly status report of applications filed with the System that is distributed to managers and others involved in the process.

Any bank holding company whose application does not meet the internal timing target, regardless of the reason or responsible party, receives a letter explaining the delay as required by Regulation Y.¹² A member of the Board must approve the letter before it is sent. Other monitoring efforts include an agenda scheduling report, monthly conference calls, and an annual applications processing conference. Applications being processed under delegated authority are tracked by

either the Reserve Bank or Board staff on an ongoing basis. More intense scrutiny typically is given to each case in which one-half of the processing period for the application has elapsed without action having been taken or without action being imminent.

Although the System monitors all phases of the applications process, the Board has emphasized the importance of minimizing the processing period and burden on the applicant associated with the entire process. Current monitoring efforts of applications are driven primarily by the post-acceptance, 60-day internal processing guideline, and to a lesser extent by the total amount of time an applicant needs to obtain regulatory approval. In an effort to heighten management's focus on this timing issue, the Board has determined that a new report will be developed. The report will be organized in chronological order and will include the total length of time an application is in process and an explanation of the application's status. The report will be distributed to the directors of the divisions that are involved in the applications process.

Change No. 8: Establishing a General Consent Limit for Investments in Bank Premises for State Member Banks

Section 24A of the Federal Reserve Act requires state member banks to obtain the Board's approval prior to making investments in bank premises that would result in the bank's aggregate level of direct and indirect investment in bank premises exceeding the bank's capital stock account.¹² The Board has determined to amend Regulation H to establish a general consent procedure that would allow a "well capitalized" state member bank that is also in generally satisfactory condition to make bank premises investments up to a certain percent of the bank's capital accounts. This would eliminate the current requirement that a state member bank obtain approval for each investment in bank premises that exceeds the bank's capital stock. A proposed revision to Regulation H to accomplish this goal, and a request for comments on this proposal, will be published shortly in a separate notice.

Invitation for Public Comment

As described above, the Board invites public comment on any additional proposals or measures the Board should consider for revising or streamlining the

¹² 12 U.S.C. 371d. Section 24A applies to: (1) Investments in bank premises, or in the stock, bonds, debentures, or other such obligations of any corporation holding the premises of such bank; and (2) the making of loans to or upon the security of the stock of any such corporation.

applications and notice procedures under the Board's rules to reduce the burden on applicants caused by the current procedures without impairing the Board's ability to fulfill its statutory obligations in reviewing applications and notices requiring Board approval.

Regulatory Flexibility Act Analysis

The Board is inviting public comment on proposals to reduce regulatory burdens imposed by the Board's procedures on bank holding companies. Pursuant to section 605(b) of the Regulatory Flexibility Act (Pub. L. 96-354, 5 U.S.C. 601 *et seq.*), the Board does not believe that these changes will have a significant adverse economic impact on a substantial number of small entities.

Paperwork Reduction Act Analysis

No collections of information pursuant to section 3504(h) of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*) are contained in these changes, and comment is invited on proposals that may reduce the current information collection requirements imposed in connection with various applications.

Board of Governors of the Federal Reserve System, August 25, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-20860 Filed 8-31-92; 8:45 am]

BILLING CODE 6210-01-F

POSTAL SERVICE

39 CFR Part 111

Collect on Delivery (COD) Mail

AGENCY: Postal Service.

ACTION: Notice of proposed rule.

SUMMARY: The Postal Service proposes amending its COD regulations to replace its current Forms 3816 and 3816-AS with multilayer forms for the mailing of COD articles. These current COD card-stock forms, however, do not adequately meet many customer and Postal Service needs. They must be taped on or tied on, and are easily torn off in mechanized handling. The redesigned multilayer forms will include a self-adhesive mailing label and a remittance coupon to be returned to the mailer with the COD payment.

DATES: Comments on the proposed rule must be received on or before October 1, 1992.

ADDRESSES: Written comments should be mailed or delivered to the Director, Office of Classification and Rates

¹¹ 12 CFR 225.14(d)(2).

Administration, U.S. Postal Service, room 8430, 475 L'Enfant Plaza SW., Washington, DC 20260-5903. Copies of all written comments will be available for inspection and photocopying between 9 a.m. and 4 p.m., Monday through Friday, at the above address.

FOR FURTHER INFORMATION CONTACT: Mary Bronson, (202) 268-5181.

SUPPLEMENTARY INFORMATION: The Postal Service currently provides two types of COD forms at no charge to mailers. Form 3816 is intended for customers who mail fewer than three COD articles at one time, Form 3816-AS is intended for customers who mail three or more articles at one time.

If the new Form 3816-AS is adopted, privately printed forms will be required to be nearly identical in design to it. Customers who are currently authorized to privately print Form 3816-AS will have until January 1, 1994, to use existing supplies and convert to the new form.

Benefits of the new forms include:

(1) Improved customer service because the remittance coupon will give the mailer all information necessary to credit the addressee's account.

(2) Provides an opportunity for automating the acceptance and carrier assignment of COD articles because the accountable mail number is preprinted in a 3-of-9 barcoded format with OCR-readable numbers below.

(3) Reduces errors in printing, reading, and filing delivery records for COD articles because the article number is preprinted.

(4) Standardizes the return envelope for all COD payments (checks made payable to the mailer and money orders issued by the delivery post office) because the remittance coupon will fit into an EM 04 penalty envelope, currently used only for money orders.

(5) Provides Form 3816-AS in a pinned continuous format so that customers can imprint COD mailing information.

(6) Standardizes and simplifies the numbering requirement for COD forms currently in DMM 914.411.

Although exempt from the notice and comment requirements of the Administrative Procedure Act ([5 U.S.C. of 553 (b), (c)]) regarding proposed rulemaking by 39 U.S.C. 410(a), the Postal Service invites public comment on the following proposed revisions to the Domestic Mail Manual, incorporated by reference in the Code of Federal Regulations (CFR). See 39 CFR 111.1.

List of Subjects in 39 CFR Part 111

Postal Service.

PART 111—[AMENDED]

1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 39 U.S.C. 101, 401, 403, 404, 3001-3011, 3201-3219, 3403-3406, 3621, 5001.

2. Amend 914.175, 914.3, 914.41, 914.51, 914.6, 914.7 and 914.8 of the Domestic Mail Manual to read as follows:

914 COLLECT ON DELIVERY (COD) MAIL

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914.175 Express Mail COD. [Deleted last sentence]

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914.3 COD Forms

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914.32 Privately Printed Forms

914.321 Authorization.

Mailers may be authorized to use specially designed and privately printed COD forms, if the requirements of 914.322 and 914.323 are met. Mailers must submit proposed COD forms for approval before printing, through the local postmaster, to the Office of Classification and Rates Administration.

914.322 Design Requirements.

a. *Format.* Forms must be nearly identical in design to forms provided by the Postal Service.

b. *Parts.* Forms must, at a minimum, consist of a delivery record identical to the delivery record of Form 3816-AS provided by the Postal Service, a remittance coupon to be returned to the mailer with the COD payment, and a mailing label.

c. *COD Number.* The COD article number must begin with the letter M followed by nine digits (see 914.411). The COD article number must be placed in the upper right corner of the form and be printed either in OCR-A font or in a barcoded format. If a barcode is used, the barcode must be:

- (1) In the 3 of 9 format.
- (2) Scannable and readable.
- (3) Printed with the corresponding human readable numbers below the barcode.

d. *COD Marking.* Forms must be conspicuously marked "COD."

e. *Order of Parts.* All the following parts, arranged in order of usage from top to bottom, are required on each COD form: delivery record, remittance coupon, and mailing label.

f. *Preprinted Mailing Information.* To facilitate processing, and if volume warrants, the postmaster may authorize mailers to type or computer print "mailed at" with the date and place of

mailing in the areas of the COD form calling for a postmark of the mailing office. The date printed on the COD form must be the same as the date the article was presented for mailing.

914.323 Construction Requirements.

a. *Size.* To facilitate filing and retrieval at the delivery office, the delivery record should be the approximate size of the Postal Service form (minimum, 3 inches by 5 inches long; maximum, 3.5 inches by 6.75 inches long).

b. *Paper Stock.* Forms must be made of paper stock with a minimum base weight of 17 pounds (17 by 22 inches, 500-sheet base) and the bottom copy (mailing label) must be coated with a glue or adhesive that can firmly attach the form to the article.

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914.33 [Renumbered as 914.322f. Renumber 914.34 as 914.33]

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914.4 Mailing

914.41 Preparation

914.411 Identification by Number.

COD articles must be identified by the same number appearing on each part of the COD form. The COD article number must begin with the letter M followed by nine digits. The Office of Classification and Rates Administration may authorize mailers who privately print their COD forms to use customer order numbers containing nine digits and the prefix M. When either Express Mail COD or registered COD service is used, the article must bear both the COD form and the appropriate Express Mail or registered mail label. (The Express Mail or registered mail article number is used if a claim or inquiry is filed.)

* * * * *

914.413 COD Forms.

The sender must securely affix a COD form to each COD article. The form must show the article number, the names and addresses of the sender and the addressee, the amount due the sender, and the money order fee necessary for cash remittance. Delivery employees must not collect the money order fee if the recipient pays by a check payable to the mailer. The post office furnishes two types of multilayer forms without charge: Form 3816, a 5-part form for customers mailing fewer than three articles at one time, and Form 3816-AS, a 3-part continuous feed form for mailers mailing three or more articles at one time.

* * * * *

914.415 Addressing.

The name and address of the person to whom the remittance is to be sent must appear in the proper spaces on the address side of the delivery office coupon and in the return address area on the COD article itself, along with the mailer endorsements for return if undeliverable. Only domestic addresses may be used. The return address appearing on the COD form must be identical to the return address on the COD article.

Exception: Mailers who use privately printed COD forms (see 914.32) may print a different address on the remittance coupon where payments are to be sent. The mailer's address where undeliverable articles are to be returned must appear on the other parts of the COD form.

914.418 Remittance by Express Mail.

[Replace current text with the following:] Mailers may choose to have COD payments remitted to them by Express Mail and have the postage costs charged to their Express Mail Corporate Account (EMCA). To receive this service, mailers must mark the applicable box on the remittance coupon of the COD form and enter their EMCA number.

914.5 Delivery

914.51 Procedure

914.513 Obtaining Signatures.

Have recipient or authorized representative sign the delivery record part of the COD form. The delivery employee must sign and enter the date of delivery on the delivery record and must remove and retain the remittance coupon that is returned to the sender with the COD payment. Do not use Form 3849 as a delivery record for ordinary COD mail.

Exception: Post offices using the Automated Delivery Receipt System (ADRS) obtain the recipient's signature on the Form 3849 generated by the system. The check or money order number is entered into the system. The COD form and the customer's receipt portion of the money order are retained at the delivery post office. If the article is Express Mail COD, the recipient signs both the Express Mail label and the Form 3849 generated by the system.

914.519 Obtaining Receipt From Sender.

[Revise first sentence as follows:] Obtain a receipt from the sender on the COD form when delivering on return to sender. [Remainder of 914.519 unchanged]

914.6 Issuance of Payment

914.61 Preparing Money Orders.

914.61e.

[Revise first sentence as follows:] Keep the remittance coupon with the money order. [remainder of 914.61e unchanged]

914.61f.

Enter the money order number and the date the money order was mailed to the sender on the delivery record portion of the COD form. [renumber 914.61f and 914.61g as 914.61g and 914.61h, respectively]

914.62 Remitting to Sender.

a. Mail the COD payment with its accompanying remittance coupon in an EM04 penalty envelope on the day of issue or not later than the following workday. If the mailer provides prepaid (or business reply) envelopes, use them instead of penalty envelopes.

b. If the sender requests that the COD payment be sent by Express Mail (see 914.418), complete Label 11-B, enter the sender's Express Mail Corporate Account number, and mail the COD payment with its remittance coupon in an Express Mail envelope on the day of issue.

914.64 Payment by Check.

914.641d

Enter the check number and the date the check was mailed to the sender on the delivery record of the COD form.

914.65 Returned Money Orders and Checks.

914.65c.

Annotate the delivery record of the COD form to show when a check has been returned and forward the returned check to the customer who issued the check.

914.7 Special Instructions

914.72 Assignment and Reporting.

914.725 Reports.

[And the following note at the end:] Note: Post offices using the Automated Delivery Receipt System (ADRS) use a combined Form 3867/3821. A separate Form 3821 is not prepared and the locked receptacle is not used.

914.726 Disposal.

[Add the following note after 914.726(b):] Note: Post offices using the Automated Delivery System (ADRS) use a combined Form 3867/3821. A separate Form 3821 is not prepared and the locked receptacle is not used.

914.73 Clearance.

914.73a

[Replace the first sentence with the following:] The carriers must account for all COD mail charged to them by turning in either undelivered articles or signed receipts, including the remittance coupons, the charges due sender, and the money order fee, if applicable. [remainder unchanged] [Add the following note after 914.73(d):] Note: Post offices using the Automated Delivery System (ADRS) use a combined Form 3867/3821. The carrier will be given a copy of the combined Form 3867/3821 as a receipt. A separate Form 3821 is not prepared and the locked receptacle is not used. In addition, use the Form 3849 generated by ADRS as the disposition record for undeliverable COD articles.

914.74 Remitting Units.

914.741 Completion of Form 3822 in Duplicate.

Each day, units delivering COD mail must complete Form 3822 in duplicate. Post offices using ADRS will use the system for generating the Form 3822.

914.743 Systems A and B.

[Add the following note after 914.743(b)(5):] Note: Post offices using the Automated Delivery System (ADRS) obtain the recipient's signature on the system generated Form 3849. The check or money order is entered into the system either at the time of clearance or when the remittances are mailed to the sender. The COD form and the customer's receipt portion of the money order are retained at the delivery post office. The signed Forms 3849 are sent to

the centralized customer inquiry center for imaging. After imaging, Forms 3849 are stored by date.

914.743b(2)

The money order clerk must: (a) verify the cash, the number of COD forms and the amount shown on Form 3822; (b) receipt and return Form 3822 in duplicate to the COD clerk; (c) issue the money orders the same day of delivery, if practical, and send with remittance coupons to mailers; (d) attach the customers' money order receipts to the corresponding COD forms and deliver them to the superintendent or designee, with adding machine tape separately listing charges and money order fees, and with funds representing COD money orders not issued; and (e) process COD forms with checks made payable to the sender under 914.64.

914.75 Main Office Window Unit.

[Add the following note at the end of 914.75(g)] Note: Post offices using the Automated Delivery Receipt System (ADRS) obtain the recipient's signature on the system generated Form 3849. The check or money order number is entered into the system either at the time of clearance or when the remittances are mailed to the sender. The COD form and customer's receipt portion of the money order are retained at the delivery post office. The signed Forms 3849 are sent to the centralized customer inquiry center for imaging. After imaging, Forms 3849 are stored by date.

a. Issue the money orders and mail the COD payments (money orders or recipients' checks) with the remittance coupons to the sender (see 914.62).

914.8 Registered COD Mail

914.81 Acceptance.

Customers mailing fewer than three articles at one time must complete Form 3806, *Receipt for Registered Mail*, and Form 3816 for each article. Customers mailing three or more articles should complete Form 3877, *Firm Mailing Book*, or an approved computer-generated facsimile (see DMM 914.416), and Form 3816-AS for each article. Check the box on the COD form marked "Registered." Affix the COD form and the registered mail Label 200 to the address side of the article.

An appropriate amendment to 39 CFR 111.3 to reflect these changes will be published if the proposed is adopted.
Stanley F. Mires,
Assistant General Counsel, Legislative
Division.

BILLING CODE 7110-12-M

Collect COD charges as shown if customer pays by check made payable to the mailer.
Collect COD charges AND Money Order Fee ONLY if paid by cash.

COD Charges (Remit to Sender)

MO Fee
\$

To:



PS Form 3816, May 1992

1 - DELIVERY
RECORD

From:

Date of Mailing

☐ Registered Mail

☐ Express Mail

☐ Form 3849-D
Requested

Date Form 3849-D Sent

COD

Date Money Order/Check Sent to Mailer

Check Number

MO Number

Delivered By

Date Delivered

Signature of Addressee

1. DO NOT allow recipient (addressee or agent) to examine contents before payment.
2. DO NOT deliver this article until payment is collected.
3. If payment is by check, enter check number above.



M 1 2 4 5 5 4 1 4 6 •



M 1 2 4 5 5 4 1 4 6 .

COD

SAVE THIS RECEIPT See reverse side for claims information. COD Charges (Remit to Sender)		MO Fee \$
To:		
From:		
☐ Registered Mail ☐ Express Mail	Date of Mailing	Date Form 3849-D Sent
☐ Form 3849-D Requested		
COD Fee		
Postage		
Check One and Enter Amount (if applicable) ☐ Special Handling ☐ Return Receipt ☐ Restricted Delivery		
Postmark		

 PS Form 3816, May 1992
 2-CUSTOMER
 RECORD


The fees for COD service include insurance against loss, rifling, or damage to the article and failure to receive the postal money order or the recipient's check (*some limitations apply - see DMM 914.11*). Coverage may not exceed the limit fixed for the insurance fee paid. Ask the postmaster for details of insurance limits and coverage. NOTE: Postmaster will not participate in any disputes regarding the recipient's check.

FILING A CLAIM: You must file a claim for loss within 1 year from the date the COD article was mailed (*within 90 days if sent by Express Mail*). You must present the original mailing receipt and evidence of value when filing a claim for a lost article. File damage claims immediately (*preferably by the recipient*). Failure to file a damage claim immediately may void payment of the claim.

When filing a damage claim, present the following:

- (1) original mailing receipt (*if available*);
- (2) parcel wrapper;
- (3) box and packing;
- (4) evidence of value, and
- (5) damaged contents.

When an article is received damaged, do not direct the recipient to return it to you, as this may also void payment of the claim. Instead, instruct the recipient to contact the local post office immediately.

PS Form 3816, May 1992 (reverse)



COD

COD Charges (Remit to Sender)		MO Fee \$	COD Fee		Postage
To:			Check One and Enter Amount (if applicable)		
			☐ Special Handling	☐ Return Receipt	☐ Restricted Delivery
From:			Postmark		
☐ Registered Mail ☐ Express Mail			Date of Mailing		
☐ Form 3849-D Requested			Date Form 3849-D Sent		

File this copy numerically and keep for 1 year



PS Form 3816, May 1992
3 - MAILING OFFICE
RECORD



M 1 2 4 5 5 4 1 4 6 .

CODMO Fee
\$

COD Charges (Remit to Sender)

To:



From:

**4 - REMITTANCE
COUPON**
PS Form 3816, May 1992☐ Remit COD Charges to Sender via
Express Mail.

EMCA No. _____

DELIVERY EMPLOYEE: Turn in this copy with
the payment you received for the COD article
and the signed delivery record.**Be sure the COD number appears
on the money order or check.****POST OFFICE:** Return this coupon to the
mailer with the money order or check. Use
envelope EM04 (mailer address will appear in
the window). Please secure this coupon in the
envelope with tape, if necessary.

**COD**

Thank You for
Using
COD Service

COD Charges (Reimburse to Sender)		MO Fee \$	
To:		From:	
 UNITED STATES POSTAL SERVICE		PS Form 3816, May 1992 5 - MAILING LABEL	

Collect COD charges as shown if customer pays by check made payable to the mailer.
Collect COD charges AND Money Order Fee ONLY if paid by cash.

COD Charges (Remit to Sender)

MO Fee
\$

To:



PS Form 3816-AS, May 1992
1 - DELIVERY
RECORD

From:

☐ Registered Mail

☐ Express Mail

☐ Form 3849-D
Requested

Date of Mailing

Date Form 3849-D Sent



M 1 2 4 5 5 4 1 4 6

COD

Date Money Order/Check Sent to Mailer

Check Number

MO Number

Delivered By

Date Delivered

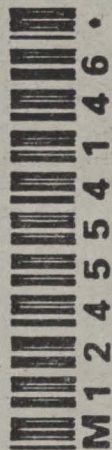
Signature of Addressee

1. DO NOT allow recipient (addressee or agent) to examine contents before payment.
2. DO NOT deliver this article until payment is collected.
3. If payment is by check, enter check number above.

1st Notice

2nd Notice

Date Returned

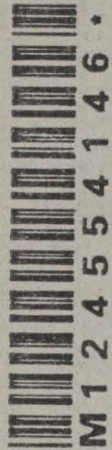
**COD**

DELIVERY EMPLOYEE: Turn in this copy with the payment you received for the COD article and the signed delivery record.

Be sure the COD number appears on the money order or check.

POST OFFICE: Return this coupon to the mailer with the money order or check. Use envelope EM04 (mailer address will appear in the window). Please secure this coupon in the envelope with tape, if necessary.

COD Charges (Remit to Sender)		MO Fee \$
		
2 - REMITTANCE COUPON PS Form 3816-AS, May 1992		
To:	From:	
☐ Remit COD Charges to Sender via Express Mail. EMCA No. _____		



COD

**Thank You for
Using
COD Service**

COD Charges (Remit to Sender)		MO Fee \$
 UNITED STATES POSTAL SERVICE 3 - MAILING LABEL PS Form 3816-AS, May 1992		
To:		
From:		

[FR Doc. 92-20810 Filed 8-31-92; 8:45 am]
BILLING CODE 7110-12-C

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL-4200-8]

National Oil and Hazardous Substances Contingency Plan; the National Priorities List

AGENCY: U.S. Environmental Protection Agency.

ACTION: Notice of intent to delete a site from the national priorities list; request for comments.

SUMMARY: The U.S. Environmental Protection Agency (EPA) announces its intent to delete the Adrian, MN site from the National Oil and Hazardous Substances Pollution Contingency Plan (NCP) National Priorities List (NPL), Appendix B, and requests public comment. EPA, in consultation with the State of Minnesota, has determined that all appropriate Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (CERCLA) actions have been implemented and no further clean-up under the authority of CERCLA is appropriate. Deletion of a site from the NPL does not preclude eligibility for subsequent Fund-financed actions if future conditions warrant such action. The purpose of this notice is to request public comment on the proposed deletion of the Adrian site from the NPL.

DATES: Comments concerning the proposed deletion of the site from the NPL may be submitted until October 1, 1992.

ADDRESSES: Comments may be mailed to Edward J. Hanlon (HSRM-6J), Remedial Project Manager, Office of Superfund, U.S. EPA, Region V, 77 West Jackson Blvd., Chicago, IL 60604; direct telephone number: (312) 353-9228, facsimile: (312) 886-4071. The comprehensive information on the site is available at the local information repository located at the office of John Moeger, Tanks and Spills Division, Minnesota Pollution Control Agency (MPCA), 520 Lafayette Rd., St. Paul, MN 55155; direct telephone number: (612) 297-8613. Requests for comprehensive copies of documents should be directed formally to the appropriate Regional Docket Office. The address for the Regional Docket Office is C. Freeman (HSMA-5J), Region V, U.S. EPA, 77 West Jackson Blvd., Chicago, IL 60604, (312) 886-6214.

FOR FURTHER INFORMATION CONTACT: Edward J. Hanlon (HSRM-6J), Remedial Project Manager, Office of Superfund, U.S. EPA, Region V, 77 West Jackson

Blvd., Chicago, IL 60604. (312) 353-9228; or Gina Weber (P19-J), Office of Public Affairs, U.S. EPA, Region V, 77 West Jackson Blvd., Chicago, IL 60604, (312) 886-6128.

SUPPLEMENTARY INFORMATION:

Table of Contents

- I. Introduction
- II. NPL Deletion Criteria
- III. Deletion Procedures
- IV. Basis for Proposed Site Deletion

I. Introduction

The U.S. Environmental Protection Agency (EPA) announces its intent to delete the Adrian site from the National Priorities List (NPL), appendix B, of the National Oil and Hazardous Substances Pollution Contingency Plan, 40 CFR part 300 (NCP), and requests comments on the deletion. The EPA identifies sites that appear to present a significant risk to public health, welfare or the environment, and maintains the NPL as the list of those sites. Sites on the NPL may be the subject of remedial actions funded either by the Hazardous Substances Response Trust Fund (Superfund) or Potentially Responsible Parties. Any site deleted from the NPL remains eligible for additional Fund-financed remedial actions in the unlikely event that conditions at the site warrant such action.

The EPA will accept comments on this proposal for 30 days after publication of this notice in the **Federal Register**.

Section II of this notice explains the criteria for deleting sites from the NPL. Section III discusses procedures that EPA is using for this action. Section IV discusses the history of this site and explains how the site meets the deletion criteria.

II. NPL Deletion Criteria

Amendments to the NCP published in the **Federal Register** on March 8, 1990 (55 FR 8813) establish the criteria the Agency uses to delete sites from the NPL. Section 300.425(e) of the NCP provides that releases may be deleted from or recategorized on the NPL where no further response is appropriate. In making this decision, EPA will consider whether any of the following criteria have been met:

(i) EPA, in consultation with the State, has determined that responsible or other parties have implemented all appropriate response actions required;

(ii) All appropriate Fund-financed response under CERCLA have been implemented, and EPA, in consultation with the State, has determined that no further clean-up by responsible parties is appropriate; or

(iii) Based on a remedial investigation, EPA, in consultation with the State, has determined that the release poses no significant threat to public health or the environment and, therefore, taking of remedial measures is not appropriate under CERCLA.

Prior to deciding to delete a site from the NPL, EPA must determine that the remedy, or existing site conditions at sites where no action is required, is protective of public health, welfare, and the environment. CERCLA, though, excludes petroleum contamination from coverage under the act and precludes use of Superfund monies from being spent to address petroleum contamination. As will be discussed further below, a determination was made to transfer responsibility of the site to another regulatory program. The UST (Underground Storage Tanks) program, established in subtitle I of the Resource Conservation and Recovery Act (RCRA), as amended by the Hazardous and Solid Waste Amendments of 1984 (HSWA) and as amended by SARA, is the regulatory authority with jurisdiction over clean-up of releases of petroleum from leaking underground storage tanks. Clean-up responsibility for the site was transferred to the U.S. EPA UST Program and the MPCA Hazardous Waste Division (Tanks and Spills Section), which has entered into a cooperative agreement with the U.S. EPA. At this time, no further action will be conducted under CERCLA.

Deletion of a site from the NPL does not preclude eligibility for subsequent additional Fund-financed actions if future site conditions warrant such actions, and they are authorized under CERCLA. Section 300.425(e)(3) of the NCP states that Fund-financed actions may be taken at sites that have been deleted from the NPL.

Deletion of sites from the NPL does not itself create, alter or revoke any individual's rights or obligations. Furthermore, deletion from the NPL does not in any way alter EPA's right to take enforcement actions, as appropriate. The NPL is designed primarily for informational purposes and to assist in Agency management.

III. Deletion Procedures

Prior to proposing deletion from the NPL, EPA must consult with the State prior to developing the Notice of Intent to Delete. In making the determination to delete a site from the NPL, EPA must consider, in consultation with the State, whether the criteria described above found in section 300.425(e)(3) have been met. Once these actions have taken

place, EPA may begin the formal deletion process by publishing a Notice of Intent to Delete in the *Federal Register*. This *Federal Register* notice, and a concurrent notice in the local newspaper in the vicinity of the site, announce the initiation of a 30-day public comment period. The public is asked to comment on EPA's intention to delete the site from the NPL; all critical documents needed to evaluate EPA's decision are generally included in the information repository and deletion docket. EPA will accept comments for a period of thirty (30) calendar days starting today.

Upon completion of the public comment period, the EPA Regional Office will prepare a Responsiveness Summary to evaluate and address concerns which were raised. The summary will be placed in the Docket and information repository. The public is welcome to contact the EPA Regional Office to obtain a copy of this responsiveness summary, when available. If EPA determines that deletion from the NPL is appropriate after close of the public comment period, a final notice announcing the deletion will be published in the *Federal Register*.

IV. Basis for Proposed Site Deletion

The following summary provides the Agency's rationale for deleting the Site from the NPL.

The city of Adrian, with a population of approximately 1400 people, is located in west-central Nobles County in southwestern Minnesota. The area of investigation is in the north-central portion of the city along the southern bank of a channel occupied by Kanaranzi Creek. The city uses 6 water supply wells, two of which produce from outwash deposits and channels along Kanaranzi Creek. Sampling of these water supply wells in September 1983 by the Minnesota Department of Health (MDH) indicated 1,2-dichloroethane (1,2 DCA) was found at a concentration of 16 ppb in Well No. 3, exceeding the 9.4 ppb human health water quality criterion for 1,2 DCA. Well No. 4 contained 3.8 ppb 1,2 DCA. Subsequent sampling in January 1984 for benzene in the same wells showed 88-160 ppb for Well No. 3 and 90-130 ppb benzene for Well No. 4, above the human health water quality criterion of 6.6 ppb for benzene. Upon this discovery, city Wells No. 3 and No. 4 were discontinued. Two new replacements wells were installed (No. 5 and No. 6) in 1984.

The estimated 1987 population of Adrian was 1,035 residents. All households, with one exception, are connected to the municipal water

supply. The nearest residence is one half block east of the contaminated area of groundwater. Several recreational facilities are located between the areas of contamination and the upper arm of Kanaranzi Creek, including a swimming pool, two ballfields, and a campground.

The September 1983 MDH sampling results prompted MPCA, on January 16, 1984, to authorize the use of Minnesota Environmental Response Liability Act (MERLA) funds to investigate the contamination and define short term and long term alternative water supplies. Barr Engineering was retained by MPCA to investigate the potential source and extent of the contamination. Barr located several underground storage tanks (UST's) and determined which might be sources of the 1,2 DCA, and other VOCs. In order to address the long term remediation needs for the well field, on October 15, 1984 the MPCA proposed to list the site on EPA's NPL.

In early 1986, IT corporation was retained by the MPCA to prepare a work plan for a more detailed Remedial Investigation (RI) which followed the quality assurance and scope requirements of CERCLA. After the site was placed on EPA's Final NPL on June 6, 1986, the MPCA entered into a Cooperative Agreement (CA) with the EPA in the fall of 1986 to conduct a Superfund Remedial Investigation/Feasibility Study (RI/FS).

Malcolm Pirnie Inc. was retained by MPCA in the fall 1986 to complete the RI report based on data from IT corporation and Barr Engineering Co. Since contaminants found in Adrian wells are typical of gasoline contamination, source investigations focused on nine UST's used for storage of gasoline and fuel oil within the Adrian well field. The RI located a contaminated groundwater plume moving west/northwest and approximately 2200 cubic yards of soil contamination,¹ and indicated that releases of petroleum fuels, gasoline and fuel oil were the likely cause of the contamination. No Superfund Feasibility Study (FS) was conducted because results of the RI indicated that the source of contamination to be leaking underground petroleum storage tanks and no further remediation was appropriate under CERCLA.

The Record of Decision for this site, which was signed by the Regional Administrator of EPA Region V on September 29, 1989, selected a "No Further Action" decision for this site under CERCLA and MERLA. In this case, "No Further Action" is envisioned

under CERCLA and MERLA, but additional actions are provided for under other regulatory authorities.

This decision stems from the fact that neither MERLA nor CERCLA provide the statutory authority to address sites contaminated with petroleum products. The UST program, established in Subtitle I of the Resource Conservation and Recovery Act (RCRA), as amended by the Hazardous and Solid Waste Amendments of 1984 (HSWA) and as amended by SARA, is the regulatory authority with jurisdiction over clean-up of releases of petroleum from leaking underground storage tanks. Clean-up responsibility for the site was transferred to the EPA UST Program and the MPCA Hazardous Waste Division (Tanks and Spills Section), which is acting under a cooperative agreement with the EPA. Since actions will be conducted by the MPCA to address the petroleum contamination to be addressed under the UST program, no five-year review will be conducted under CERCLA. After considering criteria regarding deletion from the NPL which are listed in the NCP and referred to above, EPA, in consultation with the State of Minnesota, has determined that all appropriate CERCLA actions have been implemented, no further clean-up under the authority of CERCLA is appropriate, and this Notice of Intent to Delete the site should be published.

Various clean-up activities pursuant to MERLA were conducted. (Activities at the site after the transfer to the UST program provided in the Record of Decision were undertaken under UST authorities.) Activated Carbon Filtration was installed and operated for city Wells No. 3 and 4 from July through November 1984. The landowners of Adrian Glass and Signs, Adrian Auto and Adrian Motel each removed two inactive underground gasoline tanks by September 1984. An inactive underground gasoline tank was removed from Adrian Tile on August 20, 1985. Between 1986 and 1991, the remaining six UST's within the area of groundwater contamination, and areas of soil contamination which could be removed in a cost-effective manner, were removed. The tanks removed prior to January 1990 were removed under the direction and oversight of MPCA's MERLA program; those after January 1990 were removed under the direction and oversight of MPCA's UST program. All remediation activities necessary to remove the sources of contamination to the groundwater have been completed.

Regarding the existing groundwater contamination which resulted from petroleum releases from the source

¹ Refer to the Record of Decision for locations and detailed discussion of the investigation.

areas, MPCA's UST program has determined the extent of the plume, and determined that the groundwater contamination has not yet reached the city of Adrian's drinking water wells which are currently in use. MPCA, through a design contractor, is currently designing a groundwater remediation remedy involving active soil venting, gas collection, and air sparging, for the purpose of removing the petroleum contaminants in the aquifer. The MPCA expects to receive a "Corrective Action Design Plan" by mid-July, 1992. Following approvals, MPCA will then solicit bids from prospective construction contractors to construct the groundwater remediation remedy.

The EPA, with the concurrence of the Minnesota Pollution Control Agency, has determined that all appropriate responses under CERCLA at the Adrian Site have been completed.

Dated: July 20, 1992.

David A. Ullrich,

Acting Regional Administrator.

[FR Doc. 92-20902 Filed 8-31-92; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Chapter I

[CC Docket No. 92-166; DA 92-1085]

Mobile Satellite Service in the Frequency Bands Above 1 GHz

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; establish advisory committee.

SUMMARY: The Commission requests comments on whether it should establish a Federal Advisory Committee to negotiate proposed technical rules to govern the provision of mobile satellite services in the 1610-1626.5 MHz and 2483.5-2500 MHz frequency bands.

DATES: Comments may be filed on or before September 14, 1992.

ADDRESSES: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Fern Jarmulnek, Satellite Radio Branch, Common Carrier Bureau, (202) 634-1682.

SUPPLEMENTARY INFORMATION:

1. The Commission is considering establishing an Advisory Committee to negotiate regulations defining the technical rules appropriate to the provision of mobile-satellite services (MSS) in the 1610-1626.5 MHz and 2483.5-2500 MHz frequency bands subject to the adoption of a Report and

Order allocating this spectrum for MSS services in ET Docket No. 92-28. The negotiations are to assist the Commission in developing regulations that will facilitate the shared use of this spectrum by the maximum number of MSS providers. Any negotiating committee would be created under the Federal Advisory Committee Act (FACA), 5 U.S.C. app. 2, and the Negotiated Rulemaking Act of 1990 (NRA), Pub. L. 101-648, November 28, 1990, and would consist of representatives of the interests that will be significantly affected by the outcome of these rules.

2. The Commission has recently proposed to reallocate the 1610-1626.5/2483.5-2500 MHz frequency bands to MSS on a co-primary basis with other allocated services in those bands. Notice of Proposed Rulemaking, FCC 92-358 (adopted August 4, 1992). This domestic allocation would conform with the international allocation that was made at the World Administrative Radio Conference, 1992 (WARC-92). Six applications have been filed seeking authority to construct and launch MSS systems in these bands. Five applicants propose low-Earth orbit (LEO) systems; one proposes a geostationary-satellite orbit (GSO) system. The only domestic user in the bands is the National Academy of Sciences, which provides radio astronomy service in the 1610.6-1613.8 MHz band segment on a secondary basis. Geostar Positioning Corporation (Geostar) is authorized to implement a radiodetermination satellite service (RDSS) system in the entire bandwidth, but the system has not been built and Geostar is in the liquidation phase of bankruptcy.

I. Regulatory Negotiation

3. Regulatory negotiation is a technique through which the Commission hopes to develop better regulations that may be implemented in a less adversarial setting. Negotiations are conducted through an Advisory Committee chartered under FACA. The goal of the Committee is to reach consensus on the language or substance of appropriate rules. If a consensus is reached, it is used as the basis of the Commission's proposal. If a consensus is not reached, majority and minority input may be used by the Commission in ultimately proposing regulations. All procedural requirements of the Administrative Procedure Act (APA) and other applicable statutes continue to apply.

4. When making a determination regarding the suitability of a proceeding for the negotiated rulemaking process, the Commission must consider whether:

- (a) There is a need for the rule.
- (b) There are a limited number of identifiable interests that will be significantly affected by the rule.
- (c) There is a reasonable likelihood that a committee can be convened with a balanced representation of persons who (1) can adequately represent the identifiable interests and (2) are willing to negotiate in good faith to reach a consensus on the proposed rules.
- (d) There is a reasonable likelihood that a committee will reach a consensus on the proposed rules within a fixed period of time.
- (e) The negotiated rulemaking procedure will not unreasonably delay the notice of proposed rulemaking and the issuance of final rules.
- (f) The agency has adequate resources and is willing to commit such resources, including technical assistance, to the committee, and
- (g) The agency will, to the maximum extent possible consistent with the legal obligations of the agency, use the consensus of the committee with respect to the proposed rules as the basis for the rules proposed by the agency for notice and comment. NRA section 3, 5 U.S.C. 583(a).

II. Subject and Scope of Rule Proposed for Negotiated Rulemaking

5. The Commission is proposing that the technical regulations to govern the provision of MSS in the 1610-1626.5/2483-2500 MHz frequency bands be developed through negotiation. We believe that the selection criteria listed above are met. Technical regulations are needed to establish and govern this service, should we adopt the allocations proposed in the *NPRM, supra*, in a manner that maximizes use of the spectrum and protects existing users from harmful interference. Affected interests are relatively small in number and these interests are likely to be adequately represented on any negotiating committee. Further, while we recognize that several of the applicants' proposed systems may be technically incompatible, we believe it is reasonably likely that the Committee could reach a consensus with respect to sharing criteria in a reasonable amount of time. We will use the consensus of the Committee as the basis for our rules to the extent possible. Nonetheless, if a consensus cannot be achieved, the majority and minority input will be considered by the Commission and will serve to expedite the issuance of a notice of proposed rulemaking and a final order. Finally, the Commission has adequate resources to devote to the negotiations.

6. The Commission has identified the following issues that should be addressed in the negotiations and incorporated in the proposed rules developed by the Committee:

(a) What technical rules should be adopted for this service so as to maximize the sharing of the spectrum and the capacity for multiple entry, and

(b) What technical rules should be adopted in order for this service to co-exist with other allocated services.

Other issues may be included by the parties. All proposals must comply with International Telecommunication Union (ITU) treaty obligations.

III. Potential Interests and Participants

7. The Commission has identified the following interests as those likely to be significantly affected by the MSS service rules:

(a) Applicants to provide MSS in the affected bands, and

(b) Existing users of the bands.

8. The following have initially been identified as potential interests should the Commission proceed with a negotiated rulemaking: American Mobile Satellite Corporation, Constellation Communications, Inc., Ellipsat Corporation, Loral Cellular Communications, Inc., Motorola Corporation, TRW, Inc., the National Academy of Sciences, and the Domestic Facilities Division, Common Carrier Bureau, Federal Communications Commission.

IV. Formation of the Negotiating Committee

A. Procedure for Establishing an Advisory Committee

9. Under FACA, an Advisory Committee may be established only after consultation with the General Service Administration (GSA) and the filing of a charter. The Commission will prepare a charter and initiate the requisite consultation process prior to formation of the Committee and the commencement of negotiations.

B. Participants

10. The number of participants in the group is estimated to be about 12 and should not exceed 25. A number larger than this could make it difficult to conduct efficient negotiations. Each interest will have the opportunity to be adequately represented, although this does not necessarily mean that each potentially affected entity will have its own representative. Further, we must be satisfied that the group, as a whole, reflects a proper balance and mix of interests.

11. Entities that will be significantly affected by the proposed rules and which believe that their interests will not be adequately represented by any entity specified in paragraph 8 above, may apply for, or nominate another entity for, membership on the Committee. Each application for nomination must include:

(a) The name of the applicant or nominee and a description of the interests the entity will represent,

(b) Evidence that the applicant or nominee is authorized to represent parties related to the interests the entity proposes to represent,

(c) A written commitment that the applicant or nominee shall actively participate in good faith in the development of the rules under consideration,

(d) The reasons that the entities specified in paragraph 8 do not adequately represent the interests of the entity submitting the application or nomination.

12. If, in response to this Notice, any additional entities request membership or representation in the negotiating group, the Commission will determine whether that entity should be added to the group. The Commission will make that decision based on whether the entity would be substantially affected by the rule and whether that entity is already adequately represented in the negotiating group.

C. Agenda

13. If the Commission decides to establish a negotiating committee and its charter is approved, it is expected that the Committee's first meeting will take place in November 1992, at the Commission's offices, Washington, DC, at a building, room, date, and time that will be announced. At this initial meeting, the committee will complete action on all procedural matters and establish a target date for submission of its recommendations. We expect that the target date would be no later than March 1, 1993. We anticipate publication of a notice of proposed rulemaking not later than May 1993.

V. Negotiation Procedures

14. The following procedures and guidelines will apply to the Committee, if formed. These procedures may be modified, however, after reviewing the comments received in response to this Notice or during the negotiation process.

A. Facilitator

15. The Commission will nominate a person to serve as a neutral facilitator for the negotiations of the Committee, subject to the approval of the

Commission by consensus. The facilitator will not be involved in the substantive development of the regulations. The facilitator's roles are to (1) chair negotiating sessions, (2) help the negotiation process run smoothly, (3) help participants define and reach a consensus, and (4) manage record-keeping and minute-keeping.

B. Good Faith Negotiations

16. Each organization—including the Commission—must designate a qualified individual to represent its interests. Thomas S. Tycz, Deputy Chief, Domestic Facilities Division, Common Carrier Bureau, will be the Commission's representative.

C. Meetings and Compensation

17. Meetings will be held in the Washington, DC area at the convenience of the Committee. The Commission, if requested, will provide the facilities needed to conduct the meetings, and will provide any necessary technical support. Private sector members of the Committee will serve without government compensation or reimbursement of expenses. Private sector members will not be special government employees for any purposes whatsoever.

D. Committee Procedures

18. Under the general guidance and direction of the facilitator, and subject to any applicable legal requirements, the members will establish the procedures for committee meetings that they consider most appropriate.

E. Consensus

19. The goal of the Committee is consensus. We expect the participants to fashion their own working definition of this term. In the event the Committee is unable to reach a consensus, majority and minority reports may be submitted and the Commission will develop its own approach. Parties to the negotiation may withdraw at any time. If this happens, the remaining committee members and the Commission will evaluate whether the Committee should continue.

F. Record of Meetings

20. Pursuant to FACA, the Committee will keep a record of all committee meetings. This record will be placed in the public docket for this rulemaking. The Commission will announce committee meetings in the **Federal Register**. These meetings will be open to the public.

VI. Conclusion

21. The Commission requests public comment on whether: (1) it should establish a Federal Advisory Committee, (2) it has properly identified the interests that are significantly affected by the key issues listed above, (3) the proposed committee membership reflects a balanced representation of these interests, and (4) regulatory negotiation is appropriate for this rulemaking.

22. Pursuant to the applicable procedures set forth in section 4(c) of the Negotiated Rulemaking Act of 1990, 5 U.S.C. 584(c), interested parties may file comments and applications for Committee membership on or before September 14, 1992. Comments and/or applications should be sent to the Office of the Secretary, CC Docket No. 92-166, Federal Communications Commission, Washington, DC 20554. Comments and applications will be available for public inspection during regular business hours in the Dockets Public Reference Room of the Federal Communications Commission, 1919 M Street NW., Washington, DC 20554.

23. For further information pertaining to the establishment of the negotiation committee and associated matters, contact Fern J. Jarmulnek, Satellite Radio Branch, 2025 M Street NW., Washington, DC 20554, (202) 634-1682.

Federal Communications Commission.

Donna R. Searcy,
Secretary.

[FR Doc. 92-20854 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 92-192, RM-7960; RM-8036]

Radio Broadcasting Services; Walton and Rochester, IN

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document requests comments on two mutually exclusive petitions for rule making seeking the allotment of FM Channel 229A. The first, filed on behalf of J.B. Ladd, seeks the allotment to Walton, Indiana, as that community's first local aural transmission service (RM-7960). The second proponent, Dowagiac Broadcasting Company, Inc. ("DBC"), licensee of Station WDOF-FM, Channel 221A, Dowagiac, Michigan, seeks the substitution of Channel 229A for Channel 221A at Rochester, Indiana, and modification of the license of

Manitou Broadcasting Corporation ("Manitou") for Station WROI (FM), Channel 221A, to enable DBC to increase its effective radiated power to 8 kilowatts (RM-8036). An Order to Show Cause to Manitou is not required as it has endorsed DBC's proposal. Canadian concurrence will be required for these proposals. Coordinates used for Walton are 40-40-45 and 86-12-39; those for Rochester are 41-03-02 and 86-15-39.

DATES: Comments must be filed on or before October 19, 1992, and reply comments on or before November 3, 1992.

ADDRESSES: Secretary, Federal Communications Commission, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioners' counsel, as follows: Lawrence Roberts and Mark N. Lipp, Esqs., Mullin, Rhyne, Emmons and Topel, P.C., 1000 Connecticut Ave., NW., suite 500, Washington, DC 20036 (counsel for J.B. Ladd); and Leonard S. Joyce, Esq., Blair, Joyce & Silva, 1825 K Street, NW., suite 510, Washington, DC 20006 (counsel for Dowagiac Broadcasting Company, Inc.).

FOR FURTHER INFORMATION CONTACT: Nancy Joyner, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rule Making, MM Docket No. 92-192, adopted July 30, 1992, and released August 26, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, Downtown Copy Center, (202) 452-1422, 1990 M St., NW., suite 840, Washington, DC 20036.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, See 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Federal Communications Commission.

Michael C. Ruger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-20932 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1039

[Ex Parte No. 346 (Sub-28)]

Rail General Exemption Authority: Export Corn and Export Soybeans

AGENCY: Interstate Commerce Commission.

ACTION: Proposed rule; extension of comment due date.

SUMMARY: By decision served July 15, 1992 (57 FR 31489, July 16, 1992), the Commission sought public comment by August 17, 1992, on whether to exempt from regulation the rail transportation of export corn and soybeans. The Commission has concluded, preliminarily, that regulation of rail transport of export corn and export soybeans is not necessary to carry out the rail transportation policy. The proposal is intended to eliminate burdensome regulatory oversight. By decision served and published July 29, 1992 (57 FR 33478), the comment due date was extended to September 16, 1992. By letters filed July 29 through August 14, 1992, a number of interested persons request a further 90-day extension of the comment due date. Parties state additional time is needed to consult experts, avoid schedule conflicts with other proceedings, assess potential impacts and prepare comments on what they view as a significant policy change. They also mention the possible impact of pending legislation on this proceeding. In view of the Commission's prior 30-day extension and its interest in expediting review of deregulatory proposals, a 30-day extension will be permitted.

DATES: Comments are due on October 16, 1992.

ADDRESSES: Send an original and 10 copies of comments referring to Ex Parte No. 346 (Sub-No. 28) to: Office of the Secretary, Case Control Branch, Interstate Commerce Commission, Washington, DC 20423.

FOR FURTHER INFORMATION CONTACT: Richard B. Felder, (202) 927-5610. [TDD for the hearing impaired: (202) 927-5721].

Decided: August 26, 1992.

By the Commission, Anne K. Quinlan,
Acting Secretary.
Anne K. Quinlan,
Acting Secretary.
[FR Doc. 92-20987 Filed 8-31-92; 8:45 am]
BILLING CODE 7035-01-M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

Endangered and Threatened Wildlife and Plants; 90-Day Finding on Petition To List the Southwestern Willow Flycatcher and Initiation of Status Review

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of petition finding and initiation of status review.

SUMMARY: The U.S. Fish and Wildlife Service (Service) announces a 90-day finding for a petition to add the southwestern willow flycatcher (*Empidonax traillii extimus*) to the List of Endangered and Threatened Wildlife and Plants. The petition has been found to present substantial information indicating that the requested action may be warranted. A status review is initiated.

DATES: The finding announced in this notice was made on August 14, 1992. To be incorporated into the one-year finding on this petition, any information should be submitted to the Service by October 1, 1992. See **ADDRESSES** below. However, the Service will continue to accept information on the status of the southwestern willow flycatcher at any time.

ADDRESSES: Information, comments, or questions concerning the southwestern willow flycatcher petition may be submitted to the Field Supervisor, Phoenix Field Office, U.S. Fish and Wildlife Service, 3616 West Thomas Road, suite 6, Phoenix, Arizona 85019. The petition, finding, supporting data, and comments will be available for public inspection, by appointment, during normal business hours at the above address.

FOR FURTHER INFORMATION CONTACT: Sam Spiller, Field Supervisor at the above address (telephone 602/379-4720 or FTS 261-4720).

SUPPLEMENTARY INFORMATION:

Background

Section 4(b)(3)(A) of the Endangered Species Act of 1973 as amended (Act) (16 U.S.C. 1531 *et seq.*), requires that the Service make a finding on whether a

petition to list, delist, or reclassify a species presents substantial scientific or commercial information to indicate that the petitioned action may be warranted. To the maximum extent practicable, this finding is to be made within 90 days of the receipt of the petition, and the finding is to be published promptly in the *Federal Register*. If the finding is positive, the Service also is required to promptly commence a status review of the species concerned.

On January 30, 1992, the Service received a petition from Kieran Suckling, David Hogan, and Robin Silver to list the southwestern willow flycatcher (*Empidonax traillii extimus*) as an endangered species. The petition also requested critical habitat be designated and the species be emergency listed. The petition was dated January 25, 1992, and co-sponsored by the Biodiversity Legal Foundation, Friends of the Owls, and Forest Guardians.

This finding is based on various documents, including published and unpublished studies, agency documents, and field survey records. All documents on which this finding is based are on file in the Fish and Wildlife Service Field Office in Phoenix, Arizona.

A species that is in danger of extinction throughout all or a significant portion of its range may be declared an endangered species under the Act. A species that is in danger of endangerment (as defined above) throughout all or a significant portion of its range may be declared a threatened species under the Act. Section 3(15) of the Act includes under the term species " * * * any subspecies * * * and any distinct population segment of any species * * * which interbreeds when mature."

The southwestern willow flycatcher is one of four subspecies of the willow flycatcher (*Empidonax traillii*) recognized in North America. The widely distributed *E. t. traillii* occurs across the northern United States from New England through northern Wyoming and Montana, and into British Columbia. *E. T. adastus* occurs from Colorado west of the plains, to the west through the intermountain states and into eastern California, eastern Oregon and eastern Washington. The range of *E. t. brewsteri* extends from coastal California (just north of Los Angeles) north, through western Oregon and Washington to Vancouver Island. The range of the southwestern willow flycatcher (*E. t. extimus*) includes southern California, southern Nevada, southern Utah, western New Mexico, and Arizona. It may also occur in southwestern Colorado, but verified

records are lacking. Several records from Baja California del Norte and Sonora indicate the subspecies had limited distribution in extreme northwestern Mexico.

The southwestern willow flycatcher is recognized as a valid subspecies. Phillips (1948) first described the subspecies, a taxon subsequently recognized and supported by Aldrich (1951), Phillips *et al.* (1964), Monson and Phillips (1981), Hubbard (1987), and Unitt (1987). The Service also recognized the *extimus* subspecies (56 FR 58804). However, the subspecies was not recognized by the American Ornithologists' Union (AOU 1957). The above information, presented by the petitioners and/or otherwise available to the Service, indicates the southwestern willow flycatcher may be listed under the Act, as " * * * any subspecies * * * and any distinct population segment of any species which interbreeds when mature" [section 3(15)].

The southwestern willow flycatcher occurs in densely vegetated riparian habitats, preferring streamside associations of cottonwood (*Populus* sp.), willow (*Salix* sp.), and other riparian vegetation (Grinnell and Miller 1944, Phillips 1948, Zimmerman 1970, Hubbard 1987, Unitt 1987). The petition contends that listing the southwestern willow flycatcher as endangered is necessary because populations have seriously declined, essential habitat is subject to widespread present and threatened destruction, and the existing regulatory mechanisms for protection are inadequate. Population declines were documented and habitat loss and modification was discussed. The petition also presented information on other, often interrelated threats to the continued existence of the southwestern willow flycatcher. These threats included brood parasitism by the brown-headed cowbird (*Molothrus ater*), replacement of native riparian vegetation by the exotic tamarisk (*Tamarix* sp.), livestock grazing, pesticide contamination, predation, and probable loss of winter habitat due to tropical deforestation.

I. Population Trends

The petitioners accurately represented the published information, which indicates that the southwestern willow flycatcher has declined throughout its range. A summary of the status of the southwestern willow flycatcher was published by Unitt (1987). Unitt reviewed historical and contemporary published records on the subspecies across its range, determining, that it had

"declined precipitously," and that "although the data reveal no trend in the past few years, the population is clearly much smaller now than 50 years ago, and no change in the factors responsible for the decline seem likely." The petitioners accurately represented new information that has become available since Unitt's (1987) summary. Recent information indicates a continuing downward trend of the population (Brown 1991, Whitfield and Laymon unpublished data).

In the January 6, 1989, Animal Notice of Review (54 FR 554), the Service listed the southwestern willow flycatcher as a Category 2 species. Category 2 species are those species for which information in the possession of the Service indicates that proposing to list as endangered or threatened is possibly appropriate, but for which conclusive data on biological vulnerability and threat are not currently available to support proposed rules. In the November 21, 1991, Animal Notice of Review (56 FR 58804), the Service elevated the southwestern willow flycatcher to Category 1 status. Category 1 status indicates that the Service has sufficient information to propose listing a species as threatened or endangered but a proposed rule has yet to be issued because the action is precluded at present by other listing activities. The majority of the southwestern willow flycatcher's range lies within California, Arizona, and New Mexico (Phillips 1948, Unitt 1987). Each of those states list the willow flycatcher as endangered on their respective lists of threatened, endangered and/or sensitive species (Arizona Game and Fish Department 1988, New Mexico Department of Game and Fish 1988, California Department of Fish and Game 1991). Population trends by state are briefly discussed below.

California

Southwestern willow flycatchers were common breeders in coastal southern California (Willet 1912, 1933). Egg collections confirmed it must have been common in the Los Angeles basin, the San Bernardino/Riverside area and San Diego County (Unitt 1987). Collections by Brown, discussed in Unitt (1987), suggest the subspecies was also a common breeder along the lower Colorado River near Yuma in 1902. California may have once supported the majority of nesting southwestern willow flycatchers.

The subspecies is no longer known to nest on the lower Colorado River (Hunter *et al.* 1987, Rosenberg *et al.* 1991), and currently exists as small, widely disjunct remnant nesting groups elsewhere in the state (Unitt 1987).

Three recent status reviews (Garrett and Dunn 1981, Harris *et al.* 1986, Schlorff 1990) considered extirpation from California to be possible, even likely, in the foreseeable future. Only two nesting groups have been stable or increasing in recent years. One is on private land where threats from livestock grazing (see below) have been virtually eliminated (Harris *et al.* 1987, Whitfield 1990). However, after remaining stable for several years, this group on the Kern River experienced declines in 1991 (Whitfield and Laymon unpublished data). The other nesting group is on a military base, Camp Pendleton, where threats from cowbird parasitism (see below) have been reduced. Approximately six other nesting groups are known in California, all of which consisted of six or fewer nesting pairs in recent years (Suckling *et al.* 1992, Fish and Wildlife Service unpublished data).

Arizona

The type collection for *E. t. extimus* (by Gale Monson, May 30, 1940) came from the lower San Pedro River and was described by Phillips (1948). The former range in Arizona included the lower Colorado River (Phillips 1948, collections by Brown discussed in Unitt 1987), and also the Colorado River near the Little Colorado River confluence and Lees Ferry (Phillips pers. comm. cited in Unitt 1987). The subspecies was also known from the Santa Cruz River (Swarth 1914, Phillips 1948), the Verde River (Phillips 1948), the White River at Whiteriver, the White Mountains near Springerville and Alpine, and the Gila River at Fort Thomas (W.C. Hunter pers. comm. cited in Unitt 1987).

The subspecies is no longer known to nest on the lower Colorado River (Hunter *et al.* 1987, Rosenberg *et al.* 1991), and is known to persist elsewhere in the state in only three areas. Two are located in the Grand Canyon, and these had declined to a total of two pairs by 1991 (Brown 1991). Two possible breeding birds were seen in 1991 in the White Mountains area, known to have supported small nesting groups (Arizona Game and Fish Department unpublished data). Extensive loss and modification of riparian habitats has occurred throughout much of the state and most willow flycatcher habitat is now gone. Unitt (1987) concluded that " * * * it is clear that *extimus* has been extirpated from much of the area from which it was originally described, the riparian woodlands of southern Arizona."

New Mexico

Hubbard (1987) reviewed and summarized the flycatcher's status in New Mexico. He believes the breeding

populations to be generally confined to the regions west of the Rio Grande River, with records from Rio Grande, Chama, Zuni, San Francisco, Gila, and possibly lower Penasco drainages. Phillips (1948) also noted records from southwestern New Mexico, and from Las Vegas in the northeast.

The total range of the willow flycatcher has not been reduced in New Mexico, but numbers have likely declined (Hubbard 1987, Unitt 1987). A majority of remaining nesting southwestern willow flycatchers may occur in New Mexico (Unitt 1987). Nesting groups of 19 and 53 flycatcher pairs were found on the upper Gila River (Montgomery *et al.* 1985). Recent information on those nesting groups is not available, and Hubbard (1987) noted that data were lacking for trends of most nesting groups. Where data were available, they documented loss of a group of 15 breeding pairs by the rising waters of Elephant Butte Reservoir. Hubbard noted that this colony may have moved upstream, to new shoreline habitat created by the impoundment. However, he also found that the "virtually inescapable" conclusion was that "a decrease has occurred in the population of breeding willow flycatchers in New Mexico over historic time," resulting from habitat loss (Hubbard 1987).

Texas

The eastern edge of the southwestern willow flycatcher's range is believed to be in western Texas (Unitt 1987). Collections of the subspecies have been made at Fort Hancock on the Rio Grande (Phillips 1948), in the Guadalupe Mountains (Phillips pers. comm. cited in Unitt 1987), and the Davis Mountains (Oberholser 1974). Wauer (1973) considered the southwestern willow flycatcher a rare summer resident in Big Bend National Park. Data are lacking on current population levels and trends in Texas.

Utah

The northern limits of breeding southwestern willow flycatchers, in the eastern half of its range, are in southern Utah. However, because of intergradations with the *adustus* subspecies, the exact limits are not well defined (Behle 1985, Unitt 1987). The subspecies apparently has always been rare in southern Utah (Behle pers. comm. cited in Unitt 1987). Records that are likely to represent the *extimus* subspecies are from the Virgin River, from Saint George to Springdale (Phillips 1948), Kanab Creek near Kanab, and along the San Juan and

Colorado Rivers in southeastern Utah (Behle 1985). Other possible records corroborate the subspecies being present along the Virgin, Colorado, San Juan, and perhaps Paria Rivers (Bureau of Land Management, unpublished data).

Few data are available on population trends in southern Utah. However, loss of habitat is assumed to have reduced populations on the Virgin, Colorado, and San Juan Rivers. These losses have been due to urban and suburban expansion on the Virgin River, and inundation by Lake Powell on the Colorado and San Juan Rivers (Behle pers. comm. cited in Unitt 1987, Bureau of Land Management unpublished data).

Nevada

Unitt (1987) reported only three records for Nevada, all before 1962. Unitt (1987) and Hubbard (1987) both considered extreme southern Nevada to be within the subspecies' range. However, no recent data are available on population levels or trends.

Colorado

It is unknown whether the southwestern willow flycatcher occurs in Colorado. Some authors believe the subspecies may range into extreme southwestern Colorado (e.g. Hubbard (1987); others do not (e.g. Unitt 1987). Willow flycatchers in this region display considerable individual variation, and may represent intergrades between the *extimus* and *adustus* subspecies (Phillips 1948). There are not recent data on current population levels or trends from this area.

Mexico

Six specimens from Baja California del Norte and two from mainland Mexico (Sonora) were discussed by Unitt (1987). That author and Phillips (pers. comm. cited in Unitt 1987) believe the subspecies is not common in northwestern Mexico. There are no recent data on current population levels or trends.

II. Habitat Trends

The petitioners noted that extensive loss of southwestern willow flycatcher habitat has taken place, and that current habitat exists only as small, widely dispersed, fragmented islands. The petition indicated these habitat islands are highly vulnerable to further fragmentation and loss, and southwestern willow flycatchers inhabiting them are vulnerable to local extirpation from a variety of threats which are exacerbated by habitat fragmentation and isolation.

Widespread losses of southwestern wetlands are well-described, particularly the cottonwood-willow riparian habitats of southwestern willow flycatchers (Phillips *et al.* 1964, Bulmer and Thornburg 1988, General Accounting Office 1988, Szaro 1989, Dahl 1990, State of Arizona 1990). Dahl (1990) reviewed losses of wetlands between 1780 and the 1980's in the southwestern states: California 91%; Nevada 52%; Utah 30%; Arizona 36%; New Mexico 33%; and Texas 52%. Bulmer and Thornburg (1988) estimated losses of as much as 90% of lowland riparian habitat in Arizona. These losses have been attributed to urban encroachment, water diversion, channelization, livestock grazing, and hydrological changes resulting from numerous land uses.

Loss of the cottonwood-willow riparian forests has had widespread impact on the distribution and abundance of bird species associated with that forest type (Hunter *et al.* 1987, Hunter *et al.* 1988, Rosenberg *et al.* 1991).

The petition contends that as habitat becomes fragmented, small isolated habitat islands and their resident flycatchers are increasingly susceptible to extinction through stochastic events like floods, fire, brood parasitism, and predation.

III. Additional Threats to the Southwestern Willow Flycatcher

The petition stated that, in addition to loss of habitat and reductions in known populations, the southwestern willow flycatcher faces a variety of other, often interrelated threats to its continued existence. These include brood parasitism, invasion of habitat by exotic species, livestock grazing, pesticide contamination, predation, and probable loss of wintering habitat due to tropical deforestation.

Cowbird Parasitism

The petitioners stated that brood parasitism by the brown-headed cowbird (*Molothrus ater*) constitutes a threat to the southwestern willow flycatcher. Expansion of the range of the brown-headed cowbird and observed parasitism have been correlated with declines in various songbirds (Mayfield 1977a). The cowbird lays its eggs in the nest of other songbirds. The larger, more aggressive cowbird nestlings typically outcompete those of the host species for parental care. Several host species have experienced acute declines following the combination of habitat fragmentation and cowbird parasitism. These include the Kirtland's warbler (*Dendroica kirtlandii*) (Mayfield 1977a, 1977b), the

least Bell's vireo (*Vireo bellii pusillus*) (Pike and Hays 1991), and the willow flycatcher.

Brood parasitism of the willow flycatcher by brown-headed cowbirds is well documented (Hanna 1928, Rowley 1930, Willet 1933, Gaines 1974, Garret and Dunn 1981, Harris *et al.* 1987, Laymon *et al.* 1987, Brown 1988, 1991, Sedgewick and Knopf 1988, Whitfield 1990, Harris 1991). The effects of such parasitism include reducing overall nest success rate, overall egg-to-fledging rate, and delaying successful fledging (because of renesting attempts) (Harris 1991). Harris believes the delayed fledging may not give fledglings sufficient time to prepare for migration. The typical response to parasitism was abandonment of the nest. Willow flycatcher sometimes reneest after abandoning a nest parasitized by cowbirds. Renesting usually results in smaller clutches, further reducing overall reproductive potential (Holcomb 1974).

Habitat fragmentation is strongly associated with increased rates of brood parasitism by brown-headed cowbirds (Rothstein *et al.* 1980, Brittingham and Temple 1983, Airola 1986). Host species nesting in linear riparian habitats are particularly vulnerable to parasitism (Airola 1986, Laymon *et al.* 1987, Harris 1991, Bleitz 1956 cited in Harris 1991). Thus the habitat fragmentation described above is likely to increase the threat of cowbird parasitism.

Rothstein *et al.* (1980), Stafford and Valentine (1985), and Harris (1991) believe parasitism may be correlated with elevation, being more severe at lower elevations. Coupled with greater loss of lowland (desert) riparian habitat, the effects of habitat loss and parasitism are compounded. As discussed above, the lower Colorado River may have once been the core of this subspecies' range. Not only has this area suffered widespread habitat loss and modification, but being at a low elevation, cowbird parasitism may have been an equally potent agent of extirpation.

Tamarisk Invasion

The petitioners indicated that the rapid spread of the exotic tamarisk (*Tamarix* sp.) has impacted the southwestern willow flycatcher. Tamarisk was introduced into North America in the 1800's as an ornamental windbreak and erosion-control plant. It has spread rapidly along southwestern watercourses, typically to the detriment of native riparian vegetation, especially cottonwood/willow associations. The resulting changes include altered

floristic species composition, related changes in structure and volume of vegetation, and overall riparian ecology (Rosenberg *et al.* 1991). Changes in bird species communities resulting from invasion by tamarisk are well known. Conversion to tamarisk typically results in significant reductions or complete loss of bird species strongly associated with cottonwood-willow habitats. These include the yellow-billed cuckoo (*Coccyzus americanus*), summer tanager (*Piranga rubra*), northern oriole (*Icterus galbula*), and the southwestern willow flycatcher (Hunter *et al.* 1987, Hunter *et al.* 1988, Rosenberg *et al.* 1991).

Willow flycatchers are generally absent where the exotic tamarisk has replaced native riparian vegetation (Hunter *et al.* 1987). The *extimus* subspecies is not known to nest in tamarisk at low or high elevations (Hunter *et al.* 1987, Hunter *et al.* 1988), but has nested in tamarisk at middle elevations (Hubbard 1987, Brown 1988, 1991). The petitioners cite numerous references quantifying tamarisk invasion and associating it with woodcutting vegetation clearing, and grazing (e.g. Behle and Higgins 1959, Hunter *et al.* 1988, Rosenberg *et al.* 1991).

Livestock Grazing

The petition also presented information on the detrimental effects of livestock grazing on the southwestern willow flycatcher and its habitat. The information presented indicated that livestock grazing negatively affects willow flycatchers through three mechanisms:

1. Destruction of nests by direct physical contact with livestock (Valentine *et al.* 1988, Flett and Sanders 1987, Stafford and Valentine 1985). Studying the *brewsteri* subspecies in California, Valentine (1987) found that 8 of 20 (40%) nests were trampled by cattle.

2. Changes in riparian vegetation caused by grazing include reduction of available nesting habitat, changes in vegetation structure, and changes in hydrology that result in altered riparian ecosystems (Serena 1982, Cannon and Knopf 1984, Taylor 1986). Linear riparian habitats in arid regions are particularly vulnerable to fragmentation due to their disproportionate attractiveness to cattle (Johnson 1989).

3. Cattle attract brown-headed cowbirds, whose detrimental effects are described above (Valentine *et al.* 1988). Cowbirds are strongly associated with livestock and human agriculture. Birds nesting in linear riparian habitats are particularly vulnerable to parasitism (Airola 1986, Laymon *et al.* 1987, Harris

1991, Bleitz 1956 cited in Harris 1991). As noted above, linear riparian habitats are also vulnerable to fragmentation by grazing, which further increases the threat of parasitism.

Strong circumstantial evidence is available that livestock grazing negatively affects willow flycatchers. Pronounced increases in willow flycatcher numbers have coincided with dramatic reductions in cattle grazing (Taylor and Littlefield 1986, Taylor 1986, Harris *et al.* 1987). Southwestern willow flycatchers increased by 61% over a five-year period after grazing was reduced (Harris *et al.* 1987). Taylor and Littlefield (1986) found higher numbers of *brewsteri* willow flycatchers correlated with minimal or nonexistent livestock grazing. The petitioners also noted that most of the areas still known to support southwestern willow flycatchers have low or nonexistent levels of livestock grazing.

Water Impoundment

The petitioners stated that water developments (particularly dams) have significantly reduced southwestern willow flycatcher habitat. The series of dams along most major southwestern rivers (Colorado, Gila, Salt, Verde, Rio Grande) have altered riparian habitats downstream of dams through hydrological changes, and inundated habitats upstream of the dams. New habitat is sometimes created along the shoreline of reservoirs, but this habitat (often tamarisk) is unstable with fluctuating levels of regulated reservoirs (Grinnell 1914, Phillips *et al.* 1964, Rosenberg *et al.* 1991).

Logging

The petitioners discussed logging of southwestern forests as another potential threat to the southwestern willow flycatcher. The petitioners stated that logging increases the likelihood of damaging floods in southwestern willow flycatcher nesting habitat. The petitioners presented no information to document specific impacts of logging on southwestern willow flycatcher nesting habitat. This issue will be investigated during the Service's status review.

Tropical Deforestation

The petitioners discussed deforestation of tropical and neotropical forests as another potential threat to the southwestern willow flycatcher. The petitioners stated that the subspecies winters in tropical regions, that tropical deforestation is widespread, and that the flycatcher may therefore be limited by availability of wintering habitat as well as breeding habitat.

The petitioners presented no information to document specific impacts of tropical deforestation on wintering southwestern willow flycatchers. This issue will be investigated during the Service's status review.

Pesticides

The petitioners discussed the southwestern willow flycatcher's preference for, and former abundance in, floodplain areas that are now largely agricultural. The petitioners argued that, where flycatcher populations remain, they are in proximity to agriculture areas, with the associated pesticides and herbicides. These agents may potentially affect the southwestern willow flycatcher, through direct toxicity and/or effects on their insect food base.

The petitioners presented no specific information to document effects of pesticides. The potential for negative effects on the flycatcher will be investigated during the Service's status review.

Predation

The petitioners maintained that predation on southwestern willow flycatchers may also be a significant threat, and may be increasing with habitat fragmentation. This contention is supported by some literature. Rosenberg *et al.* (1991) found increases in the great-tailed grackle in the lower Colorado River valley. The great-tailed grackle preys heavily on the eggs and young of other birds. Breeding southwestern willow flycatchers were apparently once common in the lower Colorado River valley (see discussion above). The flycatcher is no longer known to nest in that region. Whitfield (1990) found predation was significant on southwestern willow flycatcher nests. Predation increased with decreasing distance from nests to forest edge, suggesting that habitat fragmentation may increase the threat of predation, as well as increasing the threat of brood parasitism by cowbirds.

IV. Inadequacy of Existing Regulatory Mechanisms

The petitioners discussed the inadequacy of existing regulatory mechanisms to protect the southwestern willow flycatcher and its habitat. They noted that no conservation plans or habitat restoration projects exist on flycatcher habitat managed by the U.S. Forest Service, U.S. Bureau of Land Management, National Park Service, Bureau of Reclamation, U.S. Fish and Wildlife Service, Indian Nations, or

state agencies. The petitioners discussed specific management practices of each of these agencies which have resulted in loss of southwestern willow flycatcher habitat. The petitioners noted that the only measures implemented to benefit southwestern willow flycatchers have been on private (The Nature Conservancy) and military land (U.S. Marine Corps Camp Pendleton). In the latter instance, measures implemented primarily to recover the least Bell's vireo have also benefitted the flycatcher. The southwestern willow flycatcher is currently protected under the Migratory Bird Treaty Act (16 U.S.C. 703-712).

The adequacy of existing regulatory mechanisms protecting the southwestern willow flycatcher and its habitat will be evaluated during the Service's status review.

After a review of the petition, the references cited, and information otherwise available to the Service, the Service found that the petition presented substantial information indicating that listing the southwestern willow flycatcher may be warranted. The

available information indicates that the numbers and range of the southwestern willow flycatcher have declined, in response to loss and modification of habitat, brood parasitism, predation, lack of existing regulatory mechanisms, and probably other factors yet to be defined. The Service will consider the request for emergency listing and designation of critical habitat. If the Service determines emergency listing is prudent, a proposed emergency rule will be published. If the Service determines designation of critical habitat is prudent and determinable, it will be included if a proposed rule is published.

This finding initiates a status review for the southwestern willow flycatcher as required under section 4(b)(3)(A) of the Act. Within one year of receiving the petition, the Service is required under section 4(b)(3)(B) of the Act to make a finding whether the petitioned action is warranted. The Service requests any additional data, information or comments from the public, government agencies, the scientific community, industry, or any other interested party

concerning the status of the southwestern willow flycatcher.

References Cited

A complete list of all references cited herein is available on request from the Field Supervisor, Phoenix Field Office (See ADDRESSES section).

Author

The primary author of this notice is Timothy Tibbitts of the Phoenix, Arizona Fish and Wildlife Service Ecological Services Field Office (see ADDRESSES section).

Authority: The authority for this action is 16 U.S.C. 1531-1544.

List of Subjects in 50 CFR Part 17

Endangered and threatened species, Exports, Imports, Reporting and recordkeeping requirements, and Transportation.

Dated: August 14, 1992.

Jay L. Gerst,

Acting Director, Fish and Wildlife Service.

[FR Doc. 92-20997 Filed 8-31-92; 8:45 am]

BILLING CODE 4310-55-M

Notices

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. 92-114-2]

Receipt of Permit Applications for Release into the Environment of Genetically Engineered Organisms; Correction

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice; correction.

SUMMARY: We are correcting an editorial error that appeared in a notice published in the *Federal Register* on July 23, 1992 (57 FR 32772-32773, Docket No. 92-114-1). The notice advised the public that two applications for permits to release genetically engineered organisms into the environment were being reviewed by the Animal and Plant Health Inspection Service, and that the applications had been submitted in accordance with 7 CFR part 340, which regulates the introduction of certain genetically engineered organisms and products. In the first and second lines of the fifth column of the chart on page 32772, the field test location for permit application number 92-176-01, received from the Monsanto Agricultural Company on June 24, 1992, was incorrectly listed as "Yolo County, California; Jersey County, Illinois." The correct field test location is "Collier and Lee Counties, Florida."

FOR FURTHER INFORMATION CONTACT: Dr. Arnold Foudin, Deputy Director, Biotechnology Permits, Biotechnology, Biologics, and Environmental Protection, APHIS, USDA, room 850, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, (301) 436-7612.

Done in Washington, DC, this 26th day of August 1992.

Robert Melland,

Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 92-71006 Filed 8-31-92; 8:45 am]

BILLING CODE 3410-34-M

Forest Service

Intermountain Region; Fee Schedule For Communications Uses

AGENCY: Forest Service, USDA.

ACTION: Notice of availability.

SUMMARY: The Intermountain Regional Forester has modified the fee schedule for communications uses authorized on National Forest System lands located in the States of Nevada, Utah, and portions of California, Colorado, Idaho, and Wyoming.

ADDRESSES: Copies of the schedule may be obtained by writing to the Regional Forester, Intermountain Region, 324 25th Street, Ogden, UT 84401.

FOR FURTHER INFORMATION CONTACT: Frank Elder (801) 625-5150, Recreation and Lands Staff.

SUPPLEMENTARY INFORMATION: On August 23, 1989, the Regional Forester for the Intermountain Region published a notice of adoption of fee schedule for communications uses (54 FR No. 162, pages 35019 to 35023). Congress delayed implementation of the fee schedule and directed the Forest Service to review and report to the Appropriations Committee on the ability of fee schedules to reflect values associated with local market conditions. The report was completed and sent to the Appropriations Committee in March of 1991.

The fee schedule modifications are based on the findings of the report to Congress and additional administrative review. Most of the modifications either reduce the fees adopted in 1989, or require appraisals or other sound business management principles be used to establish fees. The modified fee schedule reflects the fair market value of the authorized use as required by the Federal Land Policy and Management Act.

Dated: August 21, 1992.

Federal Register

Vol. 57, No. 170

Tuesday, September 1, 1992

Robert C. Joslin,

Deputy Regional Forester, Resources.

[FR Doc. 92-20942 Filed 8-31-92; 8:45 am]

BILLING CODE 3410-11-M

COMMISSION ON CIVIL RIGHTS

Agenda and Public Meeting of the Michigan Advisory Committee

Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights, that a planning meeting of the Michigan Advisory Committee to the Commission will be held from 9 a.m. until 5 p.m. on Tuesday, September 29, 1992 at the Omni International Hotel, 333 Jefferson Avenue, Detroit, Michigan. The purpose of this meeting is to discuss current issues, orient members, and plan future activities.

Persons desiring additional information should contact Dr. Janice G. Frazier, Committee Chairperson at (313) 964-4000 or Constance M. Davis, Regional Director of the Midwestern Regional Office, U.S. Commission on Civil Rights, at (312) 353-8311. Hearing-impaired persons who will attend the meeting and require the services of a sign language interpreter should contact the Regional Office at least five (5) working days before the scheduled date of the meeting.

The meeting will be conducted pursuant to the provisions of the rules and regulations of the Commission.

Dated at Washington, DC, August 25, 1992.
Carol Lee Hurley,

Chief, Regional Programs Coordination Unit.

[FR Doc. 92-20958 Filed 8-31-92; 8:45 am]

BILLING CODE 6335-01-M

DEPARTMENT OF COMMERCE

International Trade Administration

[A-100-003 and C-100-004]

Adoption of Additional Streamlining Procedures for the Antidumping and Countervailing Duty Investigations of Certain Steel Products From Various Countries

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: September 1, 1992.

FOR FURTHER INFORMATION CONTACT:

Ann Sebastian, APO Specialist for Investigations, at (202) 377-3354, or Gary Taverman, Division Director, Office of Antidumping Investigations, at (202) 377-0161.

SUMMARY: The International Trade Administration (ITA) is adopting the proposed additional streamlining procedure to be used in the antidumping (AD) and countervailing duty (CVD) investigations of certain steel products from various countries, as published in the *Federal Register* on August 18, 1992.

Written comments were solicited in the August 18, 1992 notice. Two parties responded favorably to this proposal. No comments in opposition to the proposal were received. Therefore, effective September 1, 1992, the records of the AD investigations of each class or kind of merchandise from one country will be combined to create a single AD record for each country, as is now being done in the CVD investigations. A single administrative protective order (APO) will apply to the consolidated record for each country subject to AD or CVD investigations. Under this procedure, respondents will now file only one set of AD or CVD questionnaire responses, as appropriate, for all relevant classes or kinds of merchandise for each country, including both the narrative response, and computer tape/diskette submissions, rather than separate responses and databases for each class or kind of merchandise subject to investigation. Likewise, only a single set of ten copies of any other submission by any party will have to be made for one country. Each party will now make only one APO version (and one public version) of any submission for each country, rather than one for each separate class or kind, or different combinations of classes or kinds of merchandise.

Only the records will be combined under a lead case number. Separate investigations for each class or kind of merchandise will continue to be conducted. This procedure will simplify the administration of the AD and CVD provisions of the Tariff Act of 1930, as amended. It will also reduce the number of filings required of parties in each investigation, and assist in preventing inadvertent APO violations.

All submissions should indicate the lead case number followed by other appropriate case numbers for that country. Lead case numbers are currently being utilized in the CVD investigations. The lead AD case numbers by country are as follows: Argentina (A-357-808), Australia (A-602-803), Austria (A-433-803), Belgium

(A-423-803), Brazil (A-351-814), Canada (A-122-820), Finland (A-405-802), France (A-427-806), Germany (A-428-813), Italy (A-475-807), Japan (A-588-824), Korea (A-580-814), Mexico (A-201-808), Netherlands (A-421-803), Poland (A-455-802), Romania (A-485-803), Spain (A-469-802), Sweden (A-401-805) and United Kingdom (A-412-814).

This will not affect the deadlines for filing applications for APO as set forth in 19 CFR 353.34(b) and 355.34(b). The Department will accept amendments to previously submitted protective order requests to reflect these changes.

Dated: August 27, 1992.

Francis J. Sailer,

Acting Assistant Secretary for Import Administration.

[FR Doc. 92-21157 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-25-M

National Oceanic and Atmospheric Administration

[Docket No. 920384-2084]

RIN 0648-AE72

Process for the Management of Highly Migratory Species

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of proposed process and request for comments; extension of the public comment period.

SUMMARY: On May 29, 1992, NMFS published a notice of a proposed agency process for implementing provisions of the Fishery Conservation Amendments of 1990 (Pub. L. 101-627) concerning the management of highly migratory species in the Atlantic Ocean, Gulf of Mexico, and Caribbean Sea (57 FR 22718). The notice proposes a process that NOAA will follow in preparing, amending, and implementing fishery management plans and identifies the opportunities for involvement by the public, the Regional Fishery Management Council, and the U.S. Commissioners (and their advisors) to the International Convention for the Conservation of Atlantic Tunas. Public comments were invited through July 28, 1992. Based upon public requests for additional time for commenting on the proposed process, NMFS extended the public comment period through August 27, 1992 (57 FR 34121). Based on further public requests for additional time, NMFS is extending the public comment through September 11, 1992.

DATES: Comments must be received on or before September 11, 1992.

ADDRESSES: Comments on proposed process should be mailed to Richard H. Schaefer, Director, Office of Fisheries Conservation and Management, National Marine Fisheries Service, 1335 East-West Highway, Silver Spring, Maryland 20910. Please mark the envelope "Highly Migratory Species Process—Comments."

FOR FURTHER INFORMATION CONTACT: Richard H. Schaefer, Director, Office of Fisheries Conservation and Management, NMFS, telephone: (301) 713-2334 or Davis A. Hays, Office of Fisheries Conservation Management, NMFS, telephone: (301) 713-2343.

Dated: August 26, 1992.

William W. Fox, Jr.,

Assistant Administrator for Fisheries National Marine Fisheries Service.

[FR Doc. 92-20992 Filed 8-27-92; 2:23 pm]

BILLING CODE 3510-22-M

Mid-Atlantic Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The Mid-Atlantic Fishery Management Council (Council) and its Demersal Species Committee, together with the Summer Flounder Industry Advisors Subcommittee, will meet on September 16-17, 1992, beginning at 10 a.m., at the Ramada Inn, 76 Industrial Highway, Essington, PA (telephone: 215-521-9600).

The Council will begin its regular session on September 16 at 8 a.m. and should adjourn at approximately 12 noon on September 17.

The Council will consider the following agenda items: (1) Hear Committee reports, (2) adopt surf clam and ocean quahog specifications for 1993; (3) discuss the Summer Flounder Fishery Management Plan; and (4) discuss other fishery management matters as deemed necessary. The Council may go into closed session (not open to the public) to discuss personnel and/or national security matters.

For more information, contact John C. Bryson, Executive Director, Mid-Atlantic Fishery Management Council, room 2115, Federal Building, 300 South New Street, Dover, DE 19901; telephone: (302) 674-2331.

Dated: August 26, 1992.

David S. Crestin,

Acting Director, Office of Fisheries Conservation and Management, National Marine Fisheries Service.

[FR Doc. 92-20984 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-22-M

North Pacific Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service, NOAA, DOC.

The North Pacific Fishery Management Council (Council), its Advisory Panel (AP) and Scientific and Statistical Committee (SSC) will hold public meetings during the week of September 21, 1992, at the Hilton Hotel, Anchorage, AK.

The Council is scheduled to convene its regular public meeting on September 22 at 10:30 a.m., possibly continuing through Sunday, September 27. A Council executive session, that is not open to the public and pertains to a briefing on current litigation and discussion of employment matters, is scheduled to begin at noon on September 22. The Council's AP and SSC will begin their public meetings on September 21 at noon at the same location as the Council. Their agenda items will be similar to that of the Council (see below). Other workgroup and committee meetings also may be scheduled on short notice throughout the meeting week.

The Council will consider the following agenda items:

- (1) Election of officers;
- (2) Reports by the Alaska Department of Fish and Game, the National Marine Fisheries Service (NMFS) and the U.S. Coast Guard, and reports on current legislation and international fisheries;
- (3) A status report on marine mammals and seabirds, and need for protective regulations;
- (4) Reports on the status of stocks for the halibut, crab, and groundfish fisheries in the Gulf of Alaska and Bering Sea/Aleutian Islands;
- (5) Consideration of release of Community Development Quota (CDQ) for pollock for late 1992 and CDQ harvest management for 1993;
- (6) Initial consideration of 1993 groundfish harvests, apportionments and prohibited species apportionments for the Gulf of Alaska and Bering Sea/Aleutian Islands;
- (7) Review and approval of observer requirements for 1993;
- (8) Review and approval of a qualitative analysis of alternatives for a Comprehensive Rationalization Program for all fisheries under the Council's jurisdiction for public review;
- (9) A status report on the Sablefish and Halibut Individual Fishing Quota program and initial review of block proposals and a 1,000-pound floor;
- (10) Initial review of analysis of optimum yield alternatives for *C. opilio* crab;

(11) Hear reports and recommendations regarding updating the habitat portion of the Council's fishery management plans, and

(12) Review the need for the Council's Salmon Fishery Management Plan.

The Council also will review and take appropriate action on the following groundfish subjects:

Groundfish Plan Amendments—Final Review

Receive workgroup report on Amendment 26, Eastern Gulf of Alaska trawl closure, and consider final approval for Secretarial review.

Groundfish Plan Amendments—Initial Review

- (a) Pribilof Island trawl closure.
- (b) Pollock "B" season delay/ Exclusive Registration Areas.
- (c) Preferential allocation of Pacific cod to gear types with low bycatch.

Groundfish Regulatory Amendments—Final Review

- (a) Fixed gear halibut prohibited species catch (PSC) in the Bering Sea/ Aleutian Islands for 1993.
- (b) Performance-based pelagic trawl definition.
- (c) Hook and line longline fair start/ gangion-cutting provisions.

Groundfish Regulatory Amendments—Initial Review

- (a) Inshore/Offshore and CDQ bycatch provisions.
- (b) Legal gear types definition.
- (c) Total catch measurement/ interactive communications.
- (d) Bycatch standards for 1993.
- (e) Groundfish seasons for 1993.

Other Groundfish Issues

- (a) Comprehensive Gulf of Alaska rockfish management plan.
- (b) Bycatch management planning and indexing halibut PSC caps to biomass/ numbers.
- (c) Discard Committee report.
- (d) Need for various outdated groundfish regulations.
- (e) Petition for pollock research from St. Paul Island.

For more information contact the North Pacific Fishery Management Council, P.O. Box 103136, Anchorage, AK 99510, (907) 271-2809.

Dated: August 26, 1992.

David S. Crestin,

Acting Director, Office of Fisheries Conservation and Management, National Marine Fisheries Service.

[FR Doc. 92-20983 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-22-M

Pacific Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The Pacific Fishery Management Council (Council) and its advisory entities will meet on September 14-18, 1992, at the Clarion Hotel (near the San Francisco Airport), 401 East Millbrae Avenue, Millbrae, CA. Except as noted below, the meetings are open to the public.

The Council will convene on September 15 at 1 p.m. in a closed session (not open to the public) to discuss personnel matters and litigation. The Council's open session will begin on September 15 at 1:30 p.m. to consider administrative and other matters, including the election of the Chair and Vice Chair of the Council, review the fiscal year 1993 budget proposal, and consider the composition of the Scientific and Statistical Committee and the advisory subpanels. Also on September 15, the Council will address allocation of Pacific halibut for the 1993 fisheries and management measures for the recreational halibut fisheries.

The public may address the Council on fisheries issues unrelated to the agenda items on September 15 at 4 p.m. Public comments that pertain to action items on the agenda will be heard during the Council's deliberations on each issue.

The Council will reconvene on September 16 at 8 a.m. to consider limited access alternatives for the coastal pelagic species fisheries. For the remainder of September 16, the entire day of September 17 and a portion of September 18, the Council will address groundfish management items:

- (1) Federal decision on license limitation.
- (2) Status of the 1992 fisheries and inseason adjustments;
- (3) Status of U.S./Canada Pacific whiting allocations;
- (4) Preliminary 1993 harvest levels;
- (5) Trawl fishery management in 1993;
- (6) Pacific whiting allocation framework;
- (7) Plan amendment to establish whiting fishery by-catch restrictions;
- (8) Regulations to control by-catch in 1993;
- (9) Individual quotas for Pacific halibut and fixed gear sablefish fisheries; and
- (10) Status of legal gear definition changes.

Following the groundfish discussion on September 18, the Council will address habitat matters and salmon management.

Salmon issues on the agenda include:

- (1) Sequence of events and status of the 1992 fisheries;
- (2) Status of five stocks of Puget Sound chinook and coho salmon;
- (3) Policy on adjustments to seasons due to unusual weather; and
- (4) Plan amendment number 11, which includes three issues:

(a) Creation of a new subarea and allocation for the recreational fishery between Cape Alava and the Queets River, (b) sharing increases in the recreational harvest in the Westport and Columbia River subareas, and (c) creation of a separate Columbia River management area between Leadbetter Point and Cape Falcon.

Other Meetings

The Scientific and Statistical Committee will meet on September 14 at 8 a.m. to address scientific issues on the Council's agenda, and reconvene on September 15 at 8 a.m. to complete its business.

The Groundfish Advisory Subpanel will meet on September 14 at 1 p.m. to address groundfish management issues on the Council's agenda, and reconvene on September 15 at 8 a.m.

The Halibut Managers Group will meet on September 14 at 7 p.m. to discuss the 1992 halibut fisheries.

The Budget Committee will meet on September 15 at 10 a.m. to review the fiscal year 1993 Council budget proposal.

The Halibut Committee will meet on September 15 at 9 a.m. to address activities affecting the habitat of fish stocks managed by the Council.

The Enforcement Consultants will meet on September 15 at 10 a.m. to address enforcement issues on the Council's agenda.

The Salmon Advisory Subpanel will meet on September 17 at 10 a.m. to address salmon management items on the Council's agenda.

Detailed agendas for the above meetings will be available to the public after September 3, 1992. For more information contact Lawrence D. Six, Executive Director, Pacific Fishery Management Council, Metro Center, suite 420, 2000 SW. First Avenue, Portland, OR 97201; telephone: (503) 326-6352.

Dated: August 26, 1992.

David S. Crestin,

Acting Director, Office of Fisheries Conservation and Management, National Marine Fisheries Service.

[FR Doc. 92-20982 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-22-M

Marine Mammals, Issuance of Permit

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

ACTION: Issuance of permit (P135C).

SUMMARY: On April 10, 1992, notice was published in the *Federal Register* (57 FR 12478) that an application had been filed by Dr. James H.W. Hain, Associated Scientists at Woods Hole, Inc., Box 721, Woods Hole, MA 02543, to take annually up to 25 right whales (*Eubalaena glacialis*), 45 humpback whales (*Megaptera novaeangliae*), 550 Atlantic bottlenose dolphins (*Tursiops truncatus*), 20 sperm whales (*Physeter macrocephalus*), 500 *Stenella* spp., 300 pilot whales (*Globicephala* spp.), 5 Cuvier's beaked whales (*Ziphius cavirostris*), 50 fin whales (*Balaenoptera physalus*), 40 minke whales (*B. acutorostrata*), 200 Atlantic white-sided dolphins (*Lagenorhynchus acutus*), 175 loggerhead turtles (*Caretta caretta*), 25 Kemp's Ridley Turtles (*Lepidochelys kempi*) and 45 leatherback turtles (*Dermochelys coriacea*). The animals would be taken by inadvertent harassment, primarily during surveys from an airship, including experiments with low-level flight and close approaches. Takes by inadvertent harassment would also occur during research involving fixed-wing aircraft, surface vessels, and underwater acoustic surveys in the continental shelf waters of the east coast of the United States out to a distance of 100 nautical miles from the shoreline.

Notice is hereby given that on August 24, 1992, as authorized by the provisions of the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361-1407) and Endangered Species Act of 1973 (16 U.S.C. 1531-1543), the National Marine Fisheries Service issued a Permit for the above taking, subject to certain conditions set forth therein.

Issuance of this Permit, as required by the Endangered Species Act of 1973, is based on the finding that such Permit: (1) Was applied for in good faith; (2) will not operate to the disadvantage of the endangered species which is the subject of the Permit; and (3) is consistent with the purposes and policies set forth in section 2 of the Act. This Permit was also issued in accordance with and is subject to the National Marine Fisheries Service regulations governing endangered fish and wildlife permits (50 CFR parts 220-222).

Documents submitted in connection with this Permit are available, by appointment, in the Permits Division, Office of Protected Resources, National Marine Fisheries Service, 1335 East-

West Highway, Room 7324, Silver Spring, MD 20910 (301/713-2289);

Director, Northeast Region, National Marine Fisheries Service, One Blackburn Drive, Gloucester, Massachusetts 01930 (508/281-9200); and

Director, Southeast Region, National Marine Fisheries Service, 9450 Koger Blvd., St. Petersburg, FL 33702 (813/893-3141).

Dated: August 24, 1992.

Charles Karnella, Ph.D.,

Acting Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 92-20960 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-22-M

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Establishment of Import Limits for Certain Cotton and Man-Made Fiber Textile Products Produced or Manufactured in Oman

August 26, 1992.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs establishing limits.

EFFECTIVE DATE: September 2, 1992.

FOR FURTHER INFORMATION CONTACT: Jennifer Tallarico, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 377-4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port or call (202) 927-5850. For information on embargoes and quota re-openings, call (202) 377-3715. For information on categories on which consultations have been requested, call (202) 377-3740.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11651 of March 3, 1972, as amended; section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854).

Inasmuch as consultations have not yet been held on a mutually satisfactory solution on Categories 341/641 and 347/348, the United States Government has decided to control imports in these categories for the twelve-month periods beginning on June 29, 1992 and extending through June 28, 1993, in the case of Categories 341/641; and beginning on May 31, 1992 and

extending through May 30, 1993, in the case of Categories 347/348.

The United States remains committed to finding a solution concerning these categories. Should such a solution be reached in consultations with the Government of Oman, further notice will be published in the **Federal Register**.

A description of the textile and apparel categories in terms of HTS numbers is available in the **CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States** (see **Federal Register** notice 56 FR 60101, published on November 27, 1991). Also see 57 FR 27031, published on June 17, 1992; and 57 FR 31494, published on July 16, 1992.

Auggie D. Tantillo,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

August 26, 1992.

Commissioner of Customs,

Department of the Treasury, Washington, DC 20229.

Dear Commissioner: Under the terms of section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); and in accordance with the provisions of Executive Order 11651 of March 3, 1972, as amended, you are directed to prohibit, effective on September 2, 1992, entry into the United States for consumption and withdrawal from warehouse for consumption of cotton and man-made fiber textile products in the following categories, produced or manufactured in Oman and exported during the twelve-month periods which began, in the case of Categories 341/641, on June 29, 1992 and extends through June 28, 1993; and, in the case of Categories 347/348, on May 31, 1992 and extends through May 30, 1993, in excess of the following limits:

Category	Twelve-month limit ¹
341/641	113,871 dozen.
347/348	617,492 dozen.

¹ The limits have not been adjusted to account for any imports exported after May 30, 1992, in the case of Categories 347/348; and June 28, 1992, in the case of Categories 341/641.

Textile products which have been exported to the United States prior to June 29, 1992, in the case of Categories 341/641; and May 31, 1992, in the case of Categories 347/348, shall not be subject to the limits established in this directive.

Textile products in Categories 341/641 and 347/348 which have been released from the custody of the U.S. Customs Service under the provisions of 19 U.S.C. 1448(b) or 1484(a)(1)(A) prior to the effective date of this directive shall not be denied entry under this directive.

In carrying out the above directions, the Commissioner of Customs should construe

entry into the United States for consumption to include entry for consumption into the Commonwealth of Puerto Rico.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception of the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Auggie D. Tantillo,

Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 92-20967 Filed 8-31-92; 8:45 am]

BILLING CODE 3510-DR-F

DEPARTMENT OF DEFENSE

Office of the Secretary of Defense

Women in the Services Advisory Committee; Meeting

AGENCY: Defense Advisory Committee on Women in the Services (DACOWITS).

ACTION: Notice of conference.

SUMMARY: Pursuant to Public Law 92-463, notice is hereby given of a forthcoming conference of the Defense Advisory Committee on Women in the Services (DACOWITS). The purpose of DACOWITS is to advise the Secretary of Defense on matters relating to women in the Services. The Committee meets semiannually.

DATES: October 18-21, 1992 (summarized agenda follows).

ADDRESSES: Seattle Marriott SeaTac Airport Hotel, 3201 S. 176 Street, Seattle, Washington, unless otherwise noted in agenda.

AGENDA: Sessions will be conducted daily and will be open to the public. The agenda will include the following:

Sunday, October 18, 1992, 7:30 a.m.-7 p.m.

Conference Registration (Former Members and Conference Participants; Briefings: Force Reductions and Restructuring; Weight Standards After Pregnancy; Sexual Harassment; National Guard Promotion Opportunities; Women's Health Issues; No-host Working Breakfast (current DACOWITS members only); Get Acquainted Luncheon (current DACOWITS members, military representatives, advisors, and liaison officers only); Subcommittee Sessions; and Social.

Monday, October 19, 1992, 9:30 a.m.-10 p.m.

Official Opening Ceremony; OSD Luncheon (By Invitation Only); Subcommittee Sessions; and OSD Reception and Dinner (By Invitation Only).

Tuesday, October 20, 1992, 7:30 a.m.-8 p.m.

Field trip to Fort Lewis, Washington (By Invitation Only), and Executive Committee Session.

Wednesday, October 21, 1992, 7:30 a.m.-11 a.m.

No-host Working Breakfast (current DACOWITS members only); Individual Review of Resolutions; General Business Session; Installation Visit Reports; Presentations by Members of the Public.

FOR FURTHER INFORMATION CONTACT:

Major Branda M. Weidner, Assistant Director, DACOWITS and Military Women Matters, OASD (Force Management and Personnel), The Pentagon, room 3D769, Washington, DC 20301-4000; telephone (703) 697-2122.

SUPPLEMENTARY INFORMATION: The following rules and regulations will govern the participation by members of the public at the conference.

(1) Members of the public will not be permitted to attend official OSD Luncheon, Field Trip, or OSD Reception and Dinner.

(2) All business sessions will be open to the public.

(3) Interested persons may submit a written statement for consideration by the Committee and/or make an oral presentation of such during the conference.

(4) Persons desiring to make an oral presentation or submit a written statement to the Committee must notify the point of contact listed above no later than September 25.

(5) Length and number of oral presentations to be made will depend on the number of requests received from members of the public.

(6) Oral presentations by members of the public will be permitted only on Wednesday, October 21, before the full Committee.

(7) Each person desiring to make an oral presentation must provide the DACOWITS office 1 copy of the presentation by October 2, and make available 175 copies of any material that is intended for distribution at the conference.

(8) Persons submitting a written statement for inclusion in the minutes of the conference must submit to the DACOWITS staff one copy either before or by the close of the conference.

(9) Other new items from members of the public may be presented in writing to any DACOWITS member for transmittal to the DACOWITS Chair or Director, DACOWITS and Military Women Matters, to consider.

(10) Members of the public will not be permitted to enter into oral discussion conducted by the Committee members at any of the sessions; however, they will be permitted to reply to questions directed to them by the members of the Committee.

(11) Members of the public will be permitted to orally question the scheduled speakers if recognized by the Chair and if time allows after the official participants have asked questions and/or made comments.

(12) Questions from the public will not be accepted during the Subcommittee Sessions, the Executive Committee Session, or the General Business Session. Sessions will be conducted daily and will be open to the public.

Dated: August 26, 1992.

Linda Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 92-20926 Filed 8-31-92; 8:45 am]

BILLING CODE 3810-01-M

Department of the Army

Final Supplemental Environmental Impact Statement for Base Realignment at Fort Huachuca, AZ

AGENCY: Department of Defense, United States Army.

ACTION: Notice of availability.

SUMMARY: The recommendation to retain Headquarters, U.S. Army Information Systems Command (USAISC) and its subordinate supporting elements at Fort Huachuca, Arizona was mandated by Public Law 101-510 (BRAC 91), the Defense Base Closure and Realignment Act of 1990. This action is additional to the consolidation of the U.S. Army Intelligence School, Fort Devens with the U.S. Army Intelligence Center and School at Fort Huachuca, as mandated by Public Law 100-526 (BRAC I). This document focuses on additional environmental and socioeconomic impacts and mitigations associated with retaining the personnel associated with USAISC at Fort Huachuca, Arizona. Additional actions that may be taken unrelated to this realignment may affect the number of positions at Fort Huachuca and the impacts are projected in this document.

No long-term adverse ecological or environmental health effects are expected due to the retention of Headquarters, USAISC and its supporting elements. The increased population is expected to be a net positive impact on the local economy. Proposed construction projects will not significantly impact environmental resources.

SCOPING: A scoping meeting was held in Sierra Vista on September 25, 1991. Public notices requesting input and comments from the public were issued

in the regional area surrounding Fort Huachuca.

The Draft Supplemental Environmental Impact Statement (SEIS) was distributed to the public and interested agencies on June 5, 1992 for a 45 day review period. A public hearing was held on June 24, 1992 in Sierra Vista concerning the Draft SEIS. The purpose of the hearing was to give individuals or groups the opportunity to comment, either orally or in writing, on the environmental, social and economic impacts of the proposed realignment as presented in the Draft SEIS. All comments were considered and incorporated into the Final Supplemental Environmental Impact Statement (SEIS), where appropriate.

A copy of the Final SEIS will automatically be mailed to those receiving the Draft SEIS and any additional individual who commented.

FOR FURTHER INFORMATION CONTACT:

Copies of the Final SEIS can be requested by contacting Mr. Alex Watt, (213) 894-5088 or by writing to: United States Army, Corps of Engineers, Los Angeles District, ATTN: CESPL-PD-RN, P.O. Box 2711, Los Angeles, CA 90053-2325.

Lewis D. Walker,

Deputy Assistant Secretary of the Army, (Environment, Safety & Occupational Health), OASA (I, L&E).

[FR Doc. 92-21035 Filed 8-31-92; 8:45 am]

BILLING CODE 3710-08-M

Environmental Assessment for Realignment Actions at Tobyhanna Army Depot, PA

AGENCY: Department of Defense.

ACTION: Findings of no significant impact.

SUMMARY: The Proposed Action is to implement the Defense Base Closure Commission's decision to realign the electronic maintenance workload at the Sacramento Army Depot (SAAD) by transferring five maintenance workloads to Tobyhanna Army Depot (TOAD), and to transfer the Air Defense electronic maintenance workload (AN/TSQ-73) from TOAD to Letterkenny Army Depot (LEAD).

The five maintenance workloads, including all applicable secondary items, sub-assemblies, and peripherals, being transferred to TOAD are: Airborne Electronics, Radio, Intelligence/Electronics/Warfare, Test Measurement and Diagnostic Equipment/Radiac, and Wire/Data/Communications/Switches. The realignment of workload from SAAD will be accomplished through "public-to-

public" competition between TOAD and the Sacramento Air Logistics Center.

The air defense electronics maintenance workload to be transferred from TOAD to LEAD, as required by the Base Closure and Realignment Act, includes receipt, storage, maintenance, and repair for the AN/TSQ-73 Air Defense Command and Control System.

The relocation of workloads to and from TOAD is expected to result in an increase of 506 civilian positions on the depot.

Alternatives considered in the Environmental Assessment (EA) include the following: Preferred Alternative, which would transfer the five maintenance workloads from SAAD to TOAD in a phase-in approach over a two-year period, and the transfer of the Air Defense Command and Control System (AN/TSQ-73) maintenance workload from TOAD to LEAD; a Modified Timing Alternative, which would transfer all five workloads into TOAD at one time, and transfer the AN/TSQ-73 Air Command and Control System maintenance workload from TOAD to LEAD; an Unsuccessful Competition Alternative, which would result in no transfers from SAAD to TOAD, but would transfer the AN/TSQ-73 Air Defense Command and Control System maintenance workload from TOAD to LEAD; and the No Action Alternative, which provides the baseline at TOAD against which the other alternatives can be compared.

None of the alternatives would require building construction or modifications at TOAD. The workload to be transferred from SAAD to TOAD is similar to work currently being performed at TOAD, and would be accommodated in existing facilities. The increased workload would result in a subsequent increase in the amount of resources consumed and wastestreams produced by the personnel and production processes at TOAD. Biological, physical, and cultural resources such as native vegetation, wildlife including threatened and endangered species, groundwater, floodplains, historic structures and archaeological sites would not be affected by this action. Other resources such as potable water, raw materials used in the production processes, and electricity would be affected due to the increased workload. Wastestreams affected would include air emissions, waste water treatment plant effluent, sanitary solid wastes, and hazardous wastes generated in the production processes. Neither the resources consumed or wastestreams produced would have significant impacts on the human environment.

Positive impacts from implementing the proposed realignment action at TOAD occur in the socioeconomic environment. Sales volume, employment, and personal income would each experience growth. However, these socioeconomic benefits would not be significant.

Based on the environmental impact analyses found in the EA, which is hereby incorporated into this Finding of No Significant Impact (FNSI), it has been determined that implementation of the proposed action would not have significant individual or cumulative impacts on the quality of the natural or the human environment. Because there would be no significant environmental impacts resulting from implementation of the proposed action, an Environmental Impact Statement is not required and will not be prepared.

DATES: Comments must be received on or before October 1, 1992.

ADDRESSES: Persons wishing to comment may obtain a copy of the EA or inquire into this FNSI by writing to the U.S. Army Corps of Engineers, Baltimore District, ATTN: CENAB-PL-EM (Mr. Larry Eastman), P.O. Box 1715, Baltimore, Maryland 21203-1715.

FOR FURTHER INFORMATION CONTACT: Questions regarding this FNSI may be directed to Mr. Larry Eastman by calling (410) 962-4938.

Lewis D. Walker,

*Deputy Assistant Secretary of the Army
(Environment, Safety & Occupational Health),
OASA (IL&E).*

[FR Doc. 92-21034 Filed 8-31-92; 8:45 am]

BILLING CODE 3710-08-M

Cancellation of the Preparation of the Programmatic Environmental Impact Statement for the Kinetic Energy Antisatellite (KE ASAT) Weapon System

AGENCY: Department of Defense, United States Army.

ACTION: Notice of intent.

SUMMARY: The proposed KE ASAT weapon system being developed by a joint Army and Air Force program office would employ ground-based missiles to intercept and disable designated target space vehicles. The current defense budget does not support pursuing Engineering and Manufacturing Developmental Testing and subsequent production and deployment of a KE ASAT system. Therefore, the Programmatic Environmental Impact Statement will not be completed at this time.

System concepts and requirements have been developed. Testing and support of the concept demonstration is occurring at Edwards Air Force Base, California. This activity is discussed in "A Kinetic Energy Anti-Satellite Demonstration/Validation Environmental Assessment (USASDC 1990)."

The KE ASAT program has been restructured to focus on technology development activities, all of which have been assessed in the previous environmental documentation. These activities specifically involve continued development of the control system and prototype interceptor.

Further surveys and analysis of the potential environmental impacts of the KE ASAT program will be formally conducted and properly documented should the program again consider plans for Engineering and Manufacturing Developmental Testing. Public notification would be made through the Federal Register, news media, and other sources as appropriate.

ADDRESSES: Deputy Commander, U.S. Army Strategic Defense Command, ATTN: CSSD-EN (David C. Hasley), P.O. Box 1500, Huntsville, AL 35807-3801.

Lewis D. Walker,

*Deputy Assistant Secretary of the Army,
(Environment, Safety and Occupational
Health, OASA (IL&E)).*

[FR Doc. 92-20950 Filed 8-31-92; 8:45 am]

BILLING CODE 3710-08-M

Department of the Navy

Planning and Steering Advisory Committee; Closed Meeting

Pursuant to the provisions of the Federal Advisory Committee Act (5 U.S.C. App. 2), notice is hereby given that the Planning and Steering Advisory Committee will meet September 21, 1992, from 0900 to 1530, at the Center for Naval Analyses, 4401 Ford Avenue, Alexandria, Virginia. This session will be closed to the public.

The purpose of this meeting is to discuss topics relevant to SSBN security. The entire agenda will consist of classified information that is specifically authorized by Executive order to be kept secret in the interest of national defense and is properly classified pursuant to such Executive order. Accordingly, the Secretary of the Navy has determined in writing that all sessions of the meeting shall be closed to the public because they concern matters listed in 552b(c)(1) of title 5, United States Code.

For further information concerning this meeting, contact: LT J. E. Williams

(OP-213E), Pentagon, Room 4D534, Washington, DC 20350, Telephone Number: (703) 697-8887.

Dated: August 18, 1992.

Wayne T. Baucino

*Lieutenant, JAGC, U.S. Naval Reserve,
Alternate Federal Register Liaison Officer.
[FR Doc. 92-20957 Filed 8-31-92; 8:45 am]*

BILLING CODE 3810-AE-F

DEPARTMENT OF EDUCATION

Advisory Committee on Student Financial Assistance; Meeting

AGENCY: Advisory Committee on Student Financial Assistance, Education.

ACTION: Notice of upcoming meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of a forthcoming hearing sponsored by the Advisory Committee on Student Financial Assistance. This notice also describes the functions of the Committee. Notice of this meeting is required under section 10(a)(2) of the Federal Advisory Committee Act. This document is intended to notify the general public.

DATES AND TIMES: Tuesday, September 15, 1992, beginning at 9 a.m. and ending at 5 p.m.

ADDRESSES: Beaver Run Resort and Conference Center, in the Theatre, Breckenridge, Colorado 80424-2115.

FOR FURTHER INFORMATION CONTACT:

Dr. Brian K. Fitzgerald, Staff Director, Advisory Committee on Student Financial Assistance, room 4600, ROB-3, 7th & D Streets, SW., Washington, DC 20202-7582 (202) 708-7439.

SUPPLEMENTARY INFORMATION: The Advisory Committee on Student Financial Assistance is established under section 491 of the Higher Education Act of 1965 as amended by Public Law 100-50 (20 U.S.C. 1098). The Advisory Committee is established to provide advice and counsel to the Congress and the Secretary of Education on student financial aid matters, including providing technical expertise with regard to systems of need analysis and application forms, making recommendations that will result in the maintenance of access to postsecondary education for low- and middle-income students, and conducting a study of institutional lending in the Stafford Student Loan Program. The Congress has also directed the Advisory Committee to assist with a series of special assessments and produce an in-

depth study of student loan simplification.

The Advisory Committee will meet in Breckenridge, Colorado on September 15, 1992, from 9 a.m. to 5 p.m.

The proposed agenda includes discussion sessions on (a) the paperwork burden experienced by financial aid officers within the current structure of the loan program; (b) simplification and standardization of forms, procedures and other aspects of guaranty operations; (c) simplification of the bank repayment process; and (4) efficient utilization of loan programs.

Records are kept of all Committee proceedings, and are available for public inspection at the Office of the Advisory Committee on Student Financial Assistance, room 4600, 7th and D Streets, SW., Washington, DC from the hours of 9 a.m. to 5:30 p.m., weekdays, except Federal holidays.

Dated: August 25, 1992.

Dr. Brian K. Fitzgerald,

Staff Director, Advisory Committee on Student Financial Assistance.

[FR Doc. 92-20923 Filed 8-31-92; 8:45 am]

BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Voluntary Agreement and Plan of Action To Implement the International Energy Program; Meetings

In accordance with section 252(c)(1)(A)(i) of the Energy Policy and Conservation Act (42 U.S.C. 6272(c)(1)(A)(i)), the following notice of meetings is provided:

1. A meeting of the Industry Advisory Board (IAB) to the International Energy Agency (IEA) will be held on Wednesday, September 9, 1992, at the offices of the Organization for Economic Cooperation and Development (OECD), 2, rue Andre Pascal, Paris, France, beginning at 10:30 a.m. The purpose of this meeting is to permit representatives of U.S. company members of the IAB to attend a meeting of a joint government/industry Design Group which has been established by the IEA's Standing Group on Emergency Questions (SEQ) for the preparation of the Seventh Allocation Systems Test (AST-7). The agenda for the meeting, which is under the control of the Design Group, is expected to be as follows:

1. Summary Record of the last meeting.
2. AST-7 Test Guide.
3. Training program for National Emergency Sharing Organizations (NESOs) and Reporting Companies.
4. Other issues concerned with the organization of AST-7.

In addition to the foregoing, there will be an informal meeting of the IAB at 9:30 a.m. on Wednesday, September 9, 1992, at the OECD to discuss possible additions and/or deletions to the agenda described above or the agenda for the meeting of the SEQ that is to take place on September 10, 1992 (see Part II below).

II. A meeting of the IAB will be held on Thursday, September 10, 1992, at the OECD, beginning at 9:30 a.m. The purpose of this meeting is to permit attendance by representatives of U.S. company members of the IAB at a meeting of the SEQ which is scheduled to be held at the OECD.

The agenda for the meeting is under the control of the IEA Secretariat. It is expected that the following draft agenda will be followed:

1. Adoption of the Agenda.
2. Summary Record of the 75th meeting.
3. Preparations for AST-7.
- Results of Design Group meeting of September 9
- Draft AST-7 Test Guide
- AST training program for NESOs and companies
- Possible media contacts on AST-7
4. IAB activities.
5. Main lines of SEQ Program of Work for 1993.
6. Emergency response situation of IEA countries and emergencies response reviews of IEA countries.
7. Emergency reserve and net import situation of IEA countries on January 1, 1992 and April 1, 1992.
8. Emergency data system and related questions.
- Monthly Oil Statistics (MOS) to May 1992
- MOS to June 1992
- Base Period Final Consumption 2Q91/1Q92
9. Any other business.
- Next meeting

As permitted by 10 CFR § 209.32, the usual 7-day period for publication of the notice of these meetings in the **Federal Register** has been shortened because unanticipated circumstances pertaining to the IEA's scheduling of these meetings delayed the issuance of this notice.

As provided in section 252(c)(1)(A)(ii) of the Energy Policy and Conservation Act, these meetings are open only to representatives of members of the IAB and their counsel, representatives of the Departments of Energy, Justice, and State, the Federal Trade Commission, the General Accounting Office, Committees of the Congress, the IEA, the Commission of the European

Communities, and invitees of the IAB, the SEQ, or the IEA.

Issued in Washington, DC, August 26, 1992.

Eric J. Fygi,

Acting General Counsel.

[FR Doc. 92-21015 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

Energy Information Administration

Agency Information Collections Under Review by the Office of Management and Budget

AGENCY: Energy Information Administration.

ACTION: Notice of request submitted for review by the Office of Management and Budget.

SUMMARY: The Energy Information Administration (EIA) has submitted the energy information collection(s) listed at the end of this notice to the Office of Management and Budget (OMB) for review under provisions of the Paperwork Reduction Act (Pub. L. No. 96-511, 44 U.S.C. 3501 *et seq.*). The listing does not include collections of information contained in new or revised regulations which are to be submitted under section 3504(h) of the Paperwork Reduction Act, nor management and procurement assistance requirements collected by the Department of Energy (DOE).

Each entry contains the following information:

- (1) The sponsor of the collection (a DOE component which term includes the Federal Energy Regulatory Commission (FERC));
- (2) Collection number(s);
- (3) Current OMB docket number (if applicable);
- (4) Collection title;
- (5) Type of request, e.g., new, revision, extension, or reinstatement;
- (6) Frequency of collection;
- (7) Response obligation, i.e., mandatory, voluntary, or required to obtain or retain benefit;
- (8) Affected public;
- (9) An estimate of the number of respondents per report period;
- (10) An estimate of the number of responses per respondent annually;
- (11) An estimate of the average hours per response;
- (12) The estimated total annual respondent burden; and
- (13) A brief abstract describing the proposed collection and the respondents.

DATES: Comments must be filed within 30 days of publication of this notice. If you anticipate that you will be

submitting comments but find it difficult to do so within the time allowed by this notice, you should advise the OMB DOE Desk Officer listed below of your intention to do so, as soon as possible. The Desk Officer may be telephoned at (202) 395-3084. (Also, please notify the EIA contact listed below.)

ADDRESSES: Address comments to the Department of Energy Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, 726 Jackson Place NW., Washington, DC 20503. (Comments should also be addressed to the Office of Statistical Standards at the address below.)

FOR FURTHER INFORMATION AND COPIES OF RELEVANT MATERIALS CONTACT: Jay Casselberry, Office of Statistical Standards, (EI-73), Forrestal Building, U.S. Department of Energy, Washington, DC 20585. Mr. Casselberry may be telephoned at (202) 254-5348.

SUPPLEMENTARY INFORMATION: The energy information collection submitted to OMB for review was:

1. Federal Energy Regulatory Commission.
2. FERC-561.
3. 1902-0099.
4. Annual Report of Interlocking Positions.
5. Extension.
6. Annually.
7. Mandatory.
8. Individuals or households.
9. 1,500 respondents.
10. 1 response per respondent.
11. .25 hour per response.
12. 375 hours.
13. This information collection is

required by section 305(c) of the Federal Power Act. The information is collected by FERC to identify persons holding interlocking positions involving public utilities and possible conflicts of interest.

Statutory Authority: Sec. 5(a), 5(b), 13(b), and 52, Public Law No. 93-275, Federal Energy Administration Act of 1974, 15 U.S.C. 764(a), 764(b), 772(b), and 790a.

Issued in Washington, DC, August 24, 1992.

Yvonne M. Bishop,

Director, Statistical Standards, Energy Information Administration.

[FR Doc. 92-21014 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

Office of Energy Research

Special Research Grant Program Notice 92-22: Program for Ecosystem Research

AGENCY: U.S. Department of Energy (DOE).

ACTION: Notice inviting grant applications.

SUMMARY: The Office of Health and Environmental Research (OHER) of the Office of Energy Research (ER), U.S. Department of Energy (DOE), hereby announces its interest in receiving applications for Special Research Grants to support a new program for global climate change research "Program for Ecosystem Research: Fundamental (PERF)." Research within PERF is intended to provide opportunities for new insights into how terrestrial ecosystems and their component organisms adjust to global climate changes. For the purposes of this notice, the global climate changes of interest include temperature, moisture, and elevated greenhouse gases. Ecosystem adjustment may be viewed as the result of (1) biological adjustments, including homeostatic (physiological, biochemical) and genetic responses at the level of the organism; and (2) ecological adjustments, including succession and hierarchical integration at the ecosystem level. Research to detect and quantify the mechanisms that control adjustment processes should be an integral part of each research application. Proposed research must include the most appropriate research technologies available (from molecular to community methods), and should be designed to contribute to the broader more holistic perspectives of terrestrial ecosystem adjustment. Cooperative multidisciplinary research that contributes to research projects organized around the following core themes is encouraged.

This notice requests grant applications for research that include the themes: (1) How terrestrial organisms respond to atmospheric and global climate changes; (2) how these responses are controlled; (3) how these responses and controls can be detected and measured; and (4) how these responses are integrated across organizational levels to produce terrestrial ecosystem adjustments. Preapplications and the grant applications should emphasize theoretical and empirical couplings of these themes.

DATES: Formal applications submitted in response to this Notice must be received by the Acquisition and Assistance Management Division by 4:30 p.m., EST, January 4, 1993, to be accepted for a merit review in February 1993 and to permit timely consideration for award in Fiscal Year 1993.

ADDRESSES: Formal applications referencing Program Notice 92-22 should be forwarded to: U.S. Department of

Energy, Office of Energy Research, Acquisition and Assistance Management Division, ER-64, Washington, DC 20585, Attn: Program Notice 92-22. The following address must be used when submitting applications by U.S. Postal Service Express, any commercial mail delivery service, or when handcarried by the applicant: U.S. Department of Energy, Acquisition and Assistance Management Division, ER-64, 19901 Germantown Road, Germantown, MD 20874.

FOR FURTHER INFORMATION CONTACT:

Drs. Clive D. Jorgensen or Jerry W. Elwood, Office of Health and Environmental Research, Environmental Sciences Division, ER-74 (GTN), U.S. Department of Energy, Washington, DC 20585, (301) 903-5778/4583, or by OMNET, C. Jorgensen or J. Elwood.

SUPPLEMENTARY INFORMATION: Potential applicants are strongly encouraged to submit a brief preapplication in accordance with 10 CFR 600.10(d)(2). The preapplication is required to provide information that can be used to arrange for adequate reviews and also to provide applicants with an indication of DOE's interest in a potential application. The preapplication will be reviewed relative to the scope and research priorities of the U.S. Global Climate Change Research Program (USGCRP), including reference to specific DOE interests described in the DOE report on Program for Ecosystem Research (PER). The preapplications should include no more than two double-spaced pages (10 pt); including proposed research; how the research will contribute an understanding of ecosystem adjustments to global climate change; names and telephone numbers for all principal investigators (PIs), co-principal investigators (Co-PIs), and collaborators; and telefax numbers and addresses for the PIs and Co-PIs. Preapplications referencing Program Notice 92-22 should be received by October 15, 1992, and sent to Dr. Clive D. Jorgensen or Dr. Jerry W. Elwood, Office of Health and Environmental Research, ER-74, Washington, DC 20585. A response to the preapplications will be communicated to the PIs and Co-PIs by November 1, 1992.

DOE has responsibility for developing energy resources, technologies, and policies to provide for the nation's energy needs in a manner that will maintain, protect, and enhance environmental quality. Complementary to this commitment, and as part of the USGCRP, DOE also addresses the question of how ecosystems respond

and adjust to global and regional climate changes. The focus of PERF on fundamental responses and control mechanisms will enhance understanding of ecological/biological processes, and provide an improved scientific basis for assessing how and at what rates terrestrial ecosystems will adjust to global climate changes, especially regional adjustments to changes in moisture, temperature, and elevated greenhouse gases.

The themes listed in the Summary must be integrated into research applications designed to focus on understanding adjustments to global climate changes. The biological adjustment processes to receive emphasis in this notice are homeostasis and genetic selection. Ecological adjustment processes to receive emphasis are hierarchical integration and succession. Brief approximate descriptions of these processes are: Homeostasis—Homeostatic adjustments are the interdependent biochemical and physiological processes. Genetic Selection—Genetic selection is used herein as the selection of genotypes best suited for the changing climates at given locations. Hierarchical Integration—The integration of specific ecological and biological responses across hierarchical levels of ecosystem organization. Also, the ecosystem is itself one level of an even broader hierarchical organization. Succession—The process of changing species composition leading, in a somewhat predictable manner, toward an adjusted state of the ecosystem.

Each application will be reviewed on its own scientific merit and how it will contribute to the ecological research goals of the USGCRP, particularly gaps in information relative to the Dynamics of Growth and Decline, Prediction of Threshold Responses, and Modeling of adjustment processes across hierarchical levels. Although it may benefit applicants to attempt some pre-review coordination with other applicants to form core research programs, coordination cannot be formalized until after the review has been completed and the research interests evaluated. To provide this formal coordination, the meritorious applications will be grouped such that the researchers can collectively provide integrated core programs for enhanced understanding and synthesis.

It is anticipated that approximately \$2 million will be available for grant awards during FY 1993, contingent upon availability of appropriated funds. Previous awards have ranged from \$50,000 up to \$225,000 per year (total costs with terms from 1 to 3 years). Most

awards are in the \$100,000 to \$175,000 per year range (total costs from \$300,000 to \$525,000 for 3 years). Similar award sizes are anticipated for new grants. Funding of multiple year grant awards is expected, and is also contingent upon availability of funds.

The technical portion of each application should not exceed 25 double-spaced 10 pt pages with one-inch margins. Lengthy applications are not encouraged, and may be returned with a request to reduce length.

Information about the development and submission of applications, eligibility limitations, evaluation, selection processes, and other policies and procedures, may be found in 10 CFR part 605. The Application Kit and Guide is available from the U.S. Department of Energy, Acquisition and Assistance Management Division, Office of Energy Research, ER-64, Washington, DC 20585. Telephone requests may be made by calling (301) 903-4208. Additional information pertaining to the Program for Ecosystem Research is also available by calling (301) 903-4208. Instructions for preparation of an application are included in the application kit. The Catalog of Federal Assistance Number for this program is 81.049.

Issued in Washington, DC, on August 24, 1992.

D.D. Mayhew,

Deputy Director for Management, Office of Energy Research.

[FR Doc. 92-21020 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

Federal Energy Regulatory Commission

[Docket Nos. CP92-657-000, et al.]

Southwest Gas Corporation, et al.; Natural Gas Certificate Filings

Take notice that the following filings have been made with the Commission:

1. Southwest Gas Corporation v. El Paso Natural Gas Company

[Docket No. CP92-657-000]

August 21, 1992.

Take notice that on August 17, 1992, Southwest Gas Corporation (Southwest), P.O. Box 98510, Las Vegas, NV 89193-8510, filed in Docket No. CP92-657-000, pursuant to Rule 206 of the Commission's Rules of Practice and Procedure (18 CFR 385.206), a complaint against El Paso Natural Gas Company (El Paso) for violations of the Natural Gas Act, Commission Regulations, Commission Policy, El Paso's effective gas tariff, El Paso's expansion certificate in Docket No. CP90-2214-000, and El

Paso's approved "Global Settlement" in Docket Nos. RP88-44-000, et al., all as more fully set forth in the complaint which is on file with the Commission and open to public inspection.

Southwest's complaint addresses the contracts executed by El Paso with the expansion shippers for service at Southwest's Southern Nevada delivery points. The areas of concern are:

1. El Paso's oversubscription of delivery point capacity at Southwest's Southern Nevada delivery points constitutes an abandonment of service to Southwest without compliance with the requirements of section 7 of the NGA.

2. The expansion shipper's contracts violate El Paso's tariff and Commission policy, by failing to designate specific maximum contract quantities for each separate delivery point. This omission also affords the expansion shippers an undue preference by allowing them delivery point flexibility not afforded other shippers.

3. The expansion shippers' contracts violate El Paso's certificate in Docket No. CP90-2214-000 by allowing the expansion shippers to designate delivery points that were not contemplated for use under the expansion.

4. The expansion shippers' contracts violate the settlement in Docket Nos. RP88-44-000, et al., and Commission policy and regulations by allowing the expansion shippers to designate firm delivery points that were already completely committed on a firm basis to Southwest.

In light of these violations of law and policy, Southwest requests the Commission to modify the contracts with the expansion shippers so as to delete the Southern Nevada delivery points previously dedicated to Southwest, and to provide such other relief as is consistent with the statutory, regulatory, tariff and policy violations committed by El Paso.

Comment date: September 21, 1992, in accordance with the first subparagraph of Standard Paragraph F at the end of this notice.

2. EnergyNorth Natural Gas, Inc., et al.

[Docket No. CI92-70-000,¹ et al.]

August 21, 1992.

Take notice that each of the Applicants listed herein filed applications on August 17, 1992, under sections 4 and 7 of the Natural Gas Act (NGA) for unlimited-term blanket certificates with pregranted

¹ This notice does not provide for consolidation for hearing of the several matters covered herein.

abandonment authorizing sales in interstate commerce for resale of all categories of natural gas subject to the Commission's NGA jurisdiction. Applicant's applications are on file with the Commission and open to public inspection.

Comment date: September 14, 1992, in accordance with Standard Paragraph J at the end of this notice.

Docket No.	Applicant
CI92-770-000	Energy North Natural Gas, Inc., 1260 Elm Street, Box 3209, Manchester, NH 03105-0329.
CI92-771-000	Kamine/Besicorp Carthage L. P.
CI92-772-000	Kamine/Besicorp Natural Dam L. P.
CI92-773-000	Kamine/Besicorp Syracuse L. P.
CI92-774-000	Kamine/Besicorp South Glens Falls L. P., 1620 Route 22 East, Union, NJ 07083.
CI92-775-000	Sioux Pointe Inc., 1325 Lewis Blvd., P.O. Box 1078, Sioux City, IA 51102.

3. ANR Pipeline Company

[Docket No. CP92-659-000]

August 25, 1992.

Take notice that on August 18, 1992, ANR Pipeline Company (ANR), 500 Renaissance Center, Detroit, Michigan 48243, filed in Docket No. CP92-659-000 a request pursuant to § 157.205 of the Commission's Regulations under the Natural Gas Act (18 CFR 157.205) for authorization to operate an existing delivery point and appurtenant facilities as a jurisdictional sales facility to deliver gas to Iowa Electric Light and Power Company (Iowa Electric), under ANR's blanket certificate issued in Docket No. CP82-480-000 pursuant to section 7 of the Natural Gas Act, all as more fully set forth in the request which is on file with the Commission and open to public inspection.

ANR states that the existing delivery point, located in Van Buren County, Iowa, was constructed and operated under Section 311 authority and that it now proposes to use the facilities to make sales deliveries of natural gas to Iowa Electric.

ANR asserts that the natural gas delivered at the proposed delivery point would be within Iowa Electric's current peak day and annual entitlements, as set forth in the service agreement under ANR's Rate Schedule CD-1.

ANR states that the proposed delivery point would have no adverse impact on

ANR's peak day and annual delivery capacity.

Comment date: October 9, 1992, in accordance with Standard Paragraph G at the end of this notice.

4. Trunkline Gas Company

[Docket No. CP92-651-000]

August 25, 1992.

Take notice that on August 12, 1992, Trunkline Gas Company (Trunkline), P.O. Box 1642, Houston, Texas 77251-1642, filed an application with the Commission in Docket No. CP92-651-000 pursuant to section 7 of the Natural Gas Act (NGA) for permission and approval to abandon a firm transportation service it provides for Chevron U.S.A., Inc. (Chevron) under Trunkline's FERC Rate Schedule T-12, all as more fully set forth in the request which is open to the public for inspection.

Trunkline proposes to abandon, at Chevron's request, a firm transportation service under Trunkline's Rate Schedule T-12 of up to forty-five percent of the capacity of Trunkline's pipeline facilities for Chevron from Grand Isle Block 95, offshore Louisiana, to Chevron's platform in South Timbalier Block 151, offshore Louisiana. Trunkline requests authority to abandon its Rate Schedule T-12 transportation service effective June 1, 1992. No facilities would be abandoned in this proposal.

Comment date: September 15, 1992, in accordance with Standard Paragraph F at the end of this notice.

5. Arkla Energy Resources, a Division of Arkla, Inc.

[Docket No. CP92-662-000]

August 25, 1992.

Take notice that on August 20, 1992, Arkla Energy Resources, a division of Arkla, Inc. (AER), Post Office Box 21734, Shreveport, Louisiana 71151, filed in Docket No. CP92-662-000 a request pursuant to § 157.205 of the Commission's Regulations to: (1) Construct and operate a new sales tap and related facilities for delivery of natural gas to Arkansas Louisiana Gas Company (ALG) for resale to domestic customers in Caddo Parish, Louisiana; (2) upgrade one existing tap for increased deliveries to ALG for resale customers in Claiborne Parish, Louisiana; and (3) abandon six domestic sales taps in Ouachita County, Arkansas and Seminole County, Oklahoma under AER's blanket certification issued in Do. CP82-384-001, pursuant to section 7 of the Natural Gas Act, all as more fully set forth in the request on file with the Commission and open to public inspection.

AER proposes to: (a) Construct and operate a 2-inch tap on AER's Line R in Caddo Parish, Louisiana for initial service to ALG's new Rural Extension No. 1307 for service to domestic and commercial customers using approximately 2,500 Mcf of natural gas per year and 50 Mcf of natural gas per peak day at an estimated cost of \$39,586; (b) upgrade and replace an existing 1-inch meter with a 2-inch meter station on AER's Line K-2 in Claiborne Parish, Louisiana for service to domestic and commercial customers on ALG's existing Rural Extension No. 699 using approximately 425 Mcf of natural gas per year and 5 Mcf of natural gas per peak day at an estimated cost of \$1,230; (c) abandon a 1-inch meter station on AER's Line K in Ouachita County, Arkansas which has been inactive for many years with an estimated abandonment cost of \$517; (d) abandon three 1-inch meter stations on AER's Line 634-1 and two 1-inch meter stations on AER's Line 634-9 in Seminole County, Oklahoma which have been inactive for many years at an estimated abandonment cost of \$625. AER states that the natural gas required for the sales services would be delivered from AER's general system supply, which is adequate to provide the service. AER states that its deliveries of natural gas to ALG are intercompany transfers that are not conducted pursuant to a FERC jurisdictional tariff and that natural gas sold would be billed at ALG's applicable retail rates as filed and effective with the appropriate state regulatory authority from time to time.

Comment date: October 9, 1992, in accordance with Standard Paragraph G at the end of this notice.

Standard Paragraphs

F. Any person desiring to be heard or make any protest with reference to said file with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to jurisdiction conferred upon the Federal Energy Regulatory Commission by sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this filing if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the certificate is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for the applicant to appear or be represented at the hearing.

G. Any person or the Commission's staff may, within 45 days after the issuance of the instant notice by the Commission, file pursuant to rule 214 of the Commission's Procedural Rules (18 CFR 385.214) a motion to intervene or notice of intervention and pursuant to § 157.205 of the Regulations under the Natural Gas Act (18 CFR 157.205) a protest to the request. If no protest is filed within the time allowed therefore, the proposed activity shall be deemed to be authorized effective the day after the time allowed for filing a protest. If a protest is filed and not withdrawn within 30 days after the time allowed for filing a protest, the instant request shall be treated as an application for authorization pursuant to section 7 of the Natural Gas Act.

Standard Paragraph

Any person desiring to be heard or make any protest with reference to said filing should on or before the comment date file with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426 a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR §§ 385.211, .214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party in any proceeding herein must file a petition to intervene in accordance with the Commission's rules.

Under the procedure herein provided for, unless otherwise advised, it will be

unnecessary for the applicant to appear or be represented at the hearing.

Lois D. Cashell,
Secretary.

[FR Doc. 92-21001 Filed 8-31-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. JD92-08552T Wyoming-33,
Docket No. JD92-08553T Wyoming-34]

State of Wyoming; NGPA Notices of Determination by Jurisdictional Agency Designating Tight Formations

August 26, 1992.

Take notice that on August 24, 1992, the Wyoming Oil and Gas Conservation Commission (Wyoming) submitted the above-referenced notices of determination pursuant to § 271.703(c)(3) of the Commission's regulations, that the Dakota (JD92-08552T) and the Frontier (JD92-08553T) Formations underlying a portion of Sweetwater County, Wyoming, qualify as tight formations under section 107(b) of the Natural Gas Policy Act of 1978. Each notice covers approximately 27,860 acres described on the attached appendix.

The notices of determination also contain Wyoming's and the Bureau of Land Management's findings that the referenced portions of the Dakota and the Frontier Formations meet the requirements of the Commission's regulations set forth in 18 CFR part 271.

The applications for determination are available for inspection, except for material which is confidential under 18 CFR 275.206, at the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington DC 20426. Persons objecting to the determinations may file a protest, in accordance with 18 CFR 275.203 and 275.204, within 20 days after the date this notice is issued by the Commission.

Lois D. Cashell,
Secretary.

Appendix

Dakota Formation—Wyoming-33 (JD92-08552T)

Frontier Formation—Wyoming-34 (JD92-08553T)

The recommended area for the two formations cover the same surface acreage in Sweetwater County, Wyoming. The area consists of approximately 92.19% Federal Minerals, 6.89% State Minerals and 0.92% Fee minerals.

Township 12 North, Range 100 West

Section 6: W/2NW/4

Township 12 North, Range 101 West

Sections 1-5, 8-11, 15-16: All

Section 12: N/2, SW/4

Section 14: N/2, SW/4, NW/4SE/4

Section 17: Lots 1-6, N/2N/2

Section 20: Lots 3-11
Section 21: Lots 3-6, N/2
Section 22: Lots 3-6, N/2
Section 23: NW/4
Tract 37

Township 13 North, Range 100 West

Section 2: SW/4NE/4, W/2, W/2SE/4

Sections 3-4, 8-10, 15-17, 20-21, 29: All

Section 5: SE/4

Section 7: Lots 7, 8, E/2, E/2SW/4

Section 11: W/2NE/4, W/2, NW/4SE/4

Section 14: N/2NW/4, SW/4NW/4, NW/4SW/4

Section 18: Lots 5-8, E/2, E/2W/2

Section 19: Lots 5-8, E/2, E/2W/2

Section 22: N/2NE/4, SW/4NE/4, W/2, NW/4SE/4

Section 30: Lots 5-8, E/2, E/2W/2

Section 31: Lots 5-8, NE/4, E/2W/2

Township 13 North, Range 101 West

Section 13: SE/4

Section 23: SE/4

Section 24, 33-34, 36: All

Section 25: Lots 1-3, E/2, NW/4

Section 26: Lots 1-9, NE/4, N/2NW/4

Section 27: SE/4

Section 32: SE/4

Section 35: Lot 1, NW/4NE/4, S/2NE/4, W/2, SE/4

Tracts 43-44

Township 14 North, Range 100 West

Section 33: SE/4NE/4, E/2SE/4

Section 34: S/2N/2, S/2

Section 35: W/2SW/4, SE/4SW/4

[FR Doc. 92-20998 Filed 8-31-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. JD92-08554T Wyoming-35]

State of Wyoming NGPA Notice of Determination by Jurisdictional Agency Designating Tight Formation

August 26, 1992.

Take notice that on August 24, 1992, the Wyoming Oil and Gas Conservation Commission (Wyoming) submitted the above-referenced notice of determination pursuant to § 271.703(c)(3) of the Commission's regulations, that the Sixth Frontier Formation underlying a portion of Fremont County, Wyoming, qualifies as a tight formation under section 107(b) of the Natural Gas Policy Act of 1978. The notice covers the following acreage:

Township 33 North, Range 95 West

Section 1: All

Section 2: NE/4, NE/4SE/4

Township 34 North, Range 95 West

Section 26: All

Section 35: All

Section 36: All

The notice of determination also contains Wyoming's findings that the referenced portion of the Sixth Frontier Formation meets the requirements of the Commission's regulations set forth in 18 CFR part 271.

The application for determination is available for inspection, except for material which is confidential under 18 CFR 275.206, at the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426. Persons objecting to the determination may file a protest, in accordance with 18 CFR 275.203 and 275.204, within 20 days after the date this notice is issued by the Commission.

Lois D. Cashell,

Secretary.

[FR Doc. 92-20999 Filed 8-31-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RS92-8-000]

Northern Natural Gas Company; Conference

August 28, 1992.

Take notice that on September 21, 1992, at 1 p.m., the Commission staff is convening a conference to discuss Northern Natural Gas Company's "draft" Order No. 636 tariff filing. This conference is a follow-up to the conference convened by the Commission staff on July 30, 1992, where the staff, representatives of Northern Natural, and parties to the restructuring proceeding discussed Northern Natural's summary proposal.

The conference will be held at the Offices of the Federal Energy Regulatory Commission, 810 First Street, NE., Hearing Room #1, Washington, DC. The conference will run for two days, convening at 9 a.m. on the second day, September 22, 1992. Attendance at the conference does not confer party status. For additional information, please contact Jane Wilson at (402) 398-7088.

Lois D. Cashell,

Secretary.

[FR Doc. 92-21000 Filed 8-31-92; 8:45 am]

BILLING CODE 6717-01-M

Office of Fossil Energy

[Docket Nos. 92-107-NG, 92-108-NG, 92-110-NG, 92-111-NG]

GPM Gas Corp., et al.; Applications for Blanket Authorization To Import and Export Natural Gas

AGENCY: Office of Fossil Energy, DOE.

ACTION: Notice of applications.

SUMMARY: The Office of Fossil Energy (FE) of the Department of Energy (DOE) gives notice that the applications identified in the attached Appendix were filed pursuant to section 3 of the Natural Gas Act and DOE Delegation Order Nos. 0204-111 and 0204-127. The applicants request blanket authorization to import and/or export natural gas, including liquefied natural gas (LNG), from and to Canada, Mexico, and other foreign countries on a short-term or spot market basis over a period of two years beginning on the date of the first delivery. The proposed imports and exports would take place at any point on the borders of the United States that would not require the construction of new pipeline or LNG processing facilities.

Copies of these applications are available for inspection and copying in the Office of Fuels Programs docket room, 3F-056, at the below address. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays. You are invited to submit protests, motions to intervene, notices of intervention, and written comments with respect to any docket listed above.

DATE: Protests, motions to intervene or notices of intervention, as applicable, requests for additional procedures and written comments are to be filed in the specific docket at the address listed below no later than 4:30 p.m., eastern time, October 1, 1992.

ADDRESSES: Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, Room 3F-056, FE-50, 1000 Independence Avenue, SW., Washington, DC 20585.

FOR FURTHER INFORMATION CONTACT: P.J. Fleming, Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-094, 1000 Independence Avenue, SW., Washington, DC 20585 (202) 586-4819.

SUPPLEMENTARY INFORMATION: Notice of these applications is consolidated for administrative reasons, but DOE is conducting separate proceedings and will issue individual decisions on each application. Any protestor, intervenor, commenter, or other respondent who wishes to participate in more than one docket must submit a separate filing in each docket. DOE's decision on applications for import authority will be made consistent with DOE's gas import policy guidelines, under which the competitiveness of an import arrangement in the market served is the primary consideration in determining whether it is in the public interest (49 FR 6684, February 22, 1984). In reviewing natural gas export applications DOE

considers domestic need for the gas and any other issue determined to be appropriate, including whether the arrangement is consistent with the DOE policy of promoting competition in the natural gas marketplace by allowing commercial parties to freely negotiate their own trade arrangements. Parties, especially those that may oppose any of these applications, should comment on these issues as they relate to the requested import/export authority. The applicants assert that their proposals are in the public interest. Parties opposing any of these applications bear the burden of overcoming these assertions.

NEPA Compliance

The National Environmental Policy Act (NEPA), 42 U.S.C. 4321 *et seq.*, requires DOE to give appropriate consideration to the environmental effects of its proposed actions. No final decision will be issued in these proceedings until DOE has met its NEPA responsibilities.

Public Comment Procedures

In response to this notice, any person may file a protest, motion to intervene or notice of intervention, as applicable, and written comments. Any person wishing to become a party to a proceeding and to have written comments considered as the basis for any decision on an application must, however, file a motion to intervene or notice of intervention, as applicable. The filing of a protest with respect to an application will not serve to make the protestant a party to that proceeding, although protests and comments received from persons who are not parties will be considered in determining the appropriate action to be taken on an application. The filing of an intervention with respect to a particular docket will not serve to make the person a party in any other docket. All protests, motions to intervene, notices of intervention, and written comments must meet the requirements that are specified by the regulations in 10 CFR part 590. Protests, motions to intervene, notices of intervention, requests for additional procedures, and written comments should be filed to the specific docket with the Office of Fuels Programs at the address listed above.

It is intended that a decisional record on an application will be developed through responses to this notice by parties, including the parties' written comments and replies thereto. Additional procedures will be used as necessary to achieve a complete understanding of the facts and issues. A

party seeking intervention may request that additional procedures be provided, such as additional written comments, an oral presentation, a conference, or trial-type hearing. Any request to file additional written comments should explain why they are necessary. Any request for an oral presentation should identify the substantial question of fact, law, or policy at issue, show that it is material and relevant to a decision in the proceeding, and demonstrate why an

oral presentation is needed. Any request for a conference should demonstrate why the conference would materially advance the proceeding. Any request for a trial-type hearing must show that there are factual issues genuinely in dispute that are relevant and material to a decision and that a trial-type hearing is necessary for a full and true disclosure of the facts.

If an additional procedure is scheduled, notice will be provided to all

parties. If no party requests additional procedures, a final opinion and order may be issued based on the official record, including the application and responses filed by parties pursuant to this notice, in accordance with 10 CFR 590.316.

Issued in Washington, DC, on August 27, 1992.

Clifford P. Tomaszewski,
Director, Office of Natural Gas, Office of
Fuels Programs, Fossil Energy.

APPENDIX

Filing date	Applicant name and docket No.	Two-year maximum			Comments
		Import volume	Export volume	Import/export volume ¹	
8/18/92	GPM Gas Corp. (92-107-NG)		100 Bcf		Exports to Mexico.
8/19/92	Petro-Canada Hydrocarbons Inc. (92-108-NG)	150 Bcf			Imports from Canada.
8/24/92	Wes Cana Energy Marketing (U.S.) Inc. (92-110-NG)			200 Bcf	Imports/Exports (including LNG) from/to any foreign country.
8/24/92	Colonial Gas Co. (92-111-NG)	20 Bcf			Imports from Canada.

¹ Represents combined total of imports and exports.

[FR Doc. 92-21003 Filed 8-31-92; 8:45 am]
BILLING CODE 6450-01-M

[Docket No. FE C&E 92-14; Certification Notice—106]

Notice of Filing Certification of Compliance: Coal Capability of New Electric Powerplant, Powerplant and Industrial Fuel Use Act

AGENCY: Office of Fossil Energy
Department of Energy.

ACTION: Notice of filing.

SUMMARY: Kamine/Besicorp Beaver Falls L.P. has submitted a coal capability self-certification pursuant to section 201 of the Powerplant and Industrial Fuel Use Act of 1978, as amended.

ADDRESSES: Copies of the self-certification filing are available for public inspection upon request in the Office of Fuels Programs, Fossil Energy, room 3F-056, FE-52, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585.

FOR FURTHER INFORMATION CONTACT: Ellen Russell at (202) 586-9625.

SUPPLEMENTARY INFORMATION: Title II of the Powerplant and Industrial Fuel Use Act of 1978 (FUA), as amended (42 U.S.C. 8301 *et seq.*), provides that no new baseload electric powerplant may be constructed or operated without the capability to use coal or another alternate fuel as a primary energy source. In order to meet the requirement of coal capability, the owner or operator

of such facilities proposing to use natural gas or petroleum as its primary energy source shall certify, pursuant to FUA section 201(d), to the Secretary of Energy prior to construction, or prior to operation as a base load powerplant, that such powerplant has the capability to use coal or another alternate fuel. Such certification establishes compliance with section 201(a) on the day it is filed with the Secretary. The Secretary is required to publish a notice in the *Federal Register* that a certification has been filed. The following owner/operator of a proposed new baseload powerplant has filed a self-certification in accordance with section 201(d).

Owner: Kamine/Besicorp Beaver Falls L.P. Union, New Jersey.

Operator: Stewart & Stevenson Operations, Inc. Houston, Texas.

Location: Beaver Falls, New York.

Plant Configuration: Combined cycle.

Capacity: 80 megawatts.

Fuel: Natural gas or number 2 fuel oil.

Purchasing Utility: Niagara Mohawk Power Corporation.

Expected In-Service Date: Before May 29, 1985.

Issued in Washington, DC on August 27, 1992.

Anthony J. Comb,

Director, Office of Coal & Electricity, Office of
Fuels Programs, Office of Fossil Energy.

[FR Doc. 92-21017 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

[Docket No. FE C&E 92-13; Certification Notice—105]

Notice of Filing Certification of Compliance: Coal Capability of New Electric Powerplant, Powerplant and Industrial Fuel Use Act

AGENCY: Office of Fossil Energy,
Department of Energy.

ACTION: Notice of filing.

SUMMARY: Sithe/Independence Power Partners, L.P. has submitted a coal capability self-certification pursuant to section 201 of the Powerplant and Industrial Fuel Use Act of 1978, as amended.

ADDRESSES: Copies of the self-certification filing are available for public inspection upon request in the Office of Fuels Programs, Fossil Energy, room 3F-056, FE-52, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585.

FOR FURTHER INFORMATION CONTACT: Ellen Russell at (202) 586-9624.

SUPPLEMENTARY INFORMATION: Title II of the Powerplant and Industrial Fuel Use Act of 1978 (FUA), as amended (42 U.S.C. 8301 *et seq.*), provides that no new baseload electric powerplant may be constructed or operated without the capability to use coal or another alternate fuel as a primary energy source. In order to meet the requirement of coal capability, the owner or operator of such facilities proposing to use natural gas or petroleum as its primary energy source shall certify, pursuant to

FUA section 201(d), to the Secretary of Energy prior to construction, or prior to operation as a base load powerplant, that such powerplant has the capability to use coal or another alternate fuel. Such certification establishes compliance with section 201(a) on the day it is filed with the Secretary. The Secretary is required to publish a notice in the **Federal Register** that a certification has been filed. The following owner/operator of a proposed new baseload powerplant has filed a self-certification in accordance with section 201(d).

Owner: Sithe/Independence Power Partners, L.P. Oswego County, New York.

Operator: Sithe/Independence Power Partners, L.P.

Location: Scriba, Oswego County, New York.

Plant Configuration: Four General Electric MS7001FA combustion turbine generators; four heat recovery steam

generators; and two multi-pressure steam turbine generators.

Capacity: 1,012 megawatts.

Fuel: Natural gas.

Purchasing Utility: Consolidated Edison and Niagara Mohawk Corporation.

Expected In-Service Date: First quarter of 1995.

Issued in Washington, DC on August 27, 1992.

Anthony J. Commo,

Director, Office of Coal & Electricity, Office of Fuels Programs, Office of Fossil Energy.

[FR Doc. 92-21016 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

Office of Hearing and Appeals

Cases Filed Week of August 14 through August 21, 1992

During the week of August 14 through August 21, 1992, the appeals and

applications for exception or other relief listed in the Appendix to this Notice were filed with the Office of Hearings and Appeals of the Department of Energy.

Under DOE procedural regulations, 10 CFR part 205, any person who will be aggrieved by the DOE action sought in these cases may file written comments on the application within ten days of service of notice, as prescribed in the procedural regulations. For purposes of the regulations, the date of service of notice is deemed to be the date of publication of this Notice or the date of receipt by an aggrieved person of actual notice, whichever occurs first. All such comments shall be filed with the Office of Hearings and Appeals, Department of Energy, Washington, DC 20585.

Dated: August 25, 1992.

Richard Dugan,

Acting Director, Office of Hearings and Appeals.

LIST OF CASES RECEIVED BY THE OFFICE OF HEARINGS AND APPEALS

[Week of August 14 through August 21, 1992]

Date	Name and location of applicant	Case No.	Type of submission
Aug. 17, 1992	Gulf/Munford, Inc., Atlanta, GA	RR300-198	Request for modification/rescission in the Gulf refund proceeding. If granted: The July 17, 1992 Decision and Order (Case No. RF300-14694) issued to Munford, Inc. would be modified regarding the firm's application for refund submitted in the Gulf refund proceeding.
Aug. 20, 1992	E. B. Brooks, Jr., Washington, D.C.	LEE-0048	Implementation of special refund procedures. If granted: The Office of Hearings & Appeals would implement Special Refund Procedures pursuant to 10 C.F.R., Part 205, Subpart V, in connection with an April 6, 1988 Consent Order entered into with E. B. Brooks, Jr.
Aug. 21, 1992	William C. Adams, Lexington, KY	LFA-0233	Appeal of a Privacy Act & FOIA denial. If granted: The July 16, 1992 denial of access to records issued by the Oak Ridge Field Office would be rescinded, and William C. Adams would receive access to records generated during his security clearance investigation.

REFUND APPLICATIONS RECEIVED

Date received	Name of refund proceeding/name of refund application	Case No.
8/14/92 thru 8/21/92	Texaco refund applications received.	RF321-19110 thru RF321-19147
8/14/92 thru 8/21/92	Gulf Oil refund applications received.	RF300-20462 thru RF300-20475
8/14/92 thru 8/21/92	Crude oil applications received.	RF272-93809 thru RF272-93818
8/18/92	Ed Foog's ARCO	RF304-13253
8/18/92	Tony's ARCO	RF304-13254
8/18/92	Tony's ARCO	RF304-13255

EXPORT-IMPORT BANK OF THE UNITED STATES

Open Meeting of the Advisory Committee of the Export-Import Bank of the United States

SUMMARY: The Advisory Committee was established by Public Law 98-181, November 30, 1983, to advise the Export-Import Bank on its programs and to provide comments for inclusion in the reports of the Export-Import Bank to the United States Congress.

TIME AND PLACE: Wednesday, September 16, 1992, from 9:30 a.m. to 12 noon. The meeting will be held at Eximbank in room 1143, 811 Vermont Avenue, NW., Washington, DC 20571.

AGENDA: The meeting agenda will include a discussion of the following topics: Status Report on Project Finance;

Subcommittee Reports: Credit Reform—Latin America—EE/CIS—and FCIA; Next Steps; and other topics.

PUBLIC PARTICIPATION: The meeting will be open to public participation; and the last 15 minutes will be set aside for oral questions or comments. Members of the public may also file written statement(s) before or after the meeting. In order to permit the Export-Import Bank to arrange suitable accommodations, members of the public who plan to attend the meeting should notify Loretta Carrier, room 935, 811 Vermont Avenue, NW., Washington, DC 20571, (202) 566-8893, not later than September 15, 1992. If any person wishes auxiliary aids (such as a sign language interpreter) or other special accommodations, please contact, prior to September 10, 1992, Loretta Carrier, room 935, 811 Vermont Avenue, NW., Washington, DC 20571.

[FR Doc. 92-21019 Filed 8-31-92; 8:45 am]

BILLING CODE 6450-01-M

Voice: (202) 566-8893 or TDD: (202) 535-3913.

FURTHER INFORMATION: For further information, contact Loretta Carrier, room 935, 811 Vermont Avenue, NW., Washington, DC 20571, (202) 566-8893. Helene H. Wall,

Vice President, Administrative and Management Services.

[FR Doc. 92-21115 Filed 8-31-92; 8:45 am]

BILLING CODE 6690-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-4201-2]

Clean Air Act; Contractor Access to Confidential Business Information

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The EPA has authorized that a subcontractor receive access to information that has been, or will be, submitted to EPA under Section 114 of the Clean Air Act (CAA) as amended. The Research Triangle Institute (RTI), Research Triangle Park, North Carolina is the primary contractor on contract 68D10143. JACA Corporation, 550 Pinetown Road, Fort Washington, Pennsylvania is the subcontractor that will provide technical assistance to RTI.

Some of the information may be claimed to be confidential business information (CBI) by the submitter.

DATES: Access to confidential data submitted to EPA will occur no sooner than August 31, 1992.

FOR FURTHER INFORMATION CONTACT: Gene W. Smith, Document Control Officer, Office of Air Quality Planning and Standards (MD-13), U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711, (919) 541-5439.

SUPPLEMENTARY INFORMATION: The EPA is issuing this notice to inform all submitters of information under Section 114 of the CAA that EPA may provide the above mentioned subcontractor access to the information on a need-to-know basis. The contractor, with the assistance of the subcontractor, will provide technical support to the Office of Air Quality Planning and Standards (OAQPS) in the development of cost, economic, and regulatory impact analyses to support the development of standards for a Federal Air Pollution Control Regulation.

In accordance with 40 CFR 2.301 (h), EPA has determined that this subcontractor requires access to CBI submitted to EPA under Sections 112

and 114 of the CAA in order to perform work under the above noted contract. The subcontractor's personnel will be given access to information submitted under Section 114 of the CAA. Some of the information may be claimed or determined to be CBI. The subcontractor's personnel will be required to sign nondisclosure agreements and will be briefed on appropriate security procedures before they are permitted access to CBI. All access to CAA CBI under this contract will take place at the subcontractor's facility. Clearance for access to CAA CBI under this contract is scheduled to expire on September 30, 1994.

Dated: August 24, 1992

Michael Shapiro,

Acting Assistant Administrator for Air and Radiation.

[FR Doc. 92-21025 Filed 8-31-92; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

[DA 92-1144]

Private Radio Bureau Seeks Comments on Dial Page, L.P.'s, Request for Rule Waiver To Implement a Digital Trunked Specialized Mobile Radio System in Nine Southeastern States

August 20, 1992.

Dial Page, L.P., seeks waiver of Commission Rules to implement a digital, trunked Specialized Mobile Radio (SMR) service in 82 predominantly secondary markets in nine southeastern States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee and Virginia. Dial Page states that its proposed system will bring the benefits of digital SMR service to users outside of metropolitan areas. The system is intended to fill in gaps between systems in major urban areas along the southeast Atlantic coast by accelerating the development of a "virtually seamless, ubiquitous network" between northern Virginia and southern Florida.

To implement its proposal, Dial Page requests waivers of (1) §§ 90.621(a)(iv) and 90.627 to allow creation of SMR systems with 40 channels per site, (2) § 90.621(b) to permit frequency re-use at multiple sites separated by less than 70 miles and (3) §§ 90.631(e) and (f) to allow an extended construction schedule. Dial Page includes in its waiver request a proposed construction schedule, an examination of the effect of its proposed system on available

spectrum in the geographic areas specified and a forecast of subscriber demand/channel requirements.

The Private Radio Bureau solicits comments on all aspects of the Dial Page proposal. Comments should be filed on or before September 30, 1992. Reply comments should be filed on or before October 19, 1992. Comments and reply comments should be addressed to: Compliance Branch, Land Mobile and Microwave Division, Private Radio Bureau, room 5202, STOP 1700A2, Federal Communications Commission, Washington, DC 20554, Reference: Case No. 92143.

Copies of the Dial Page, L.P., filing may be obtained from the Downtown Copy Center, 1990 M Street, NW., Washington, DC 20036, (202) 659-8657. A copy is also available for public inspection in Room 5202, 2025 M Street, NW., Washington, DC 20554.

For further information contact John J. Borkowski at (202) 632-7125.

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 92-20929 Filed 8-31-92; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

[FEMA-955-DR]

Florida; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Notice.

EFFECTIVE DATE: August 24, 1992.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Florida (FEMA-955-DR), dated August 24, 1992, and related determinations.

FOR FURTHER INFORMATION CONTACT: Pauline C. Campbell, Disaster Assistance Programs, Federal Emergency Management Agency, Washington, DC 20472, (202) 646-3606.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated August 24, 1992, the President declared a major disaster under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 *et seq.*).

The time period prescribed for the implementation of section 310(a), Priority to Certain Applications for Public Facility and Public Housing Assistance, 42 U.S.C. 5153, shall be for a

period not to exceed six months after the date of this declaration.

Notice is hereby given that pursuant to the authority vested in the Director of the Federal Emergency Management Agency under Executive Order 12148, I hereby appoint Major P. May of the Federal Emergency Management Agency to act as the Federal Coordinating Officer for this declared disaster.

I do hereby determine the following areas of the State of Florida to have been affected adversely by this declared major disaster:

The counties of Dade, Broward, and Monroe for Individual Assistance and Public Assistance.

(Catalog of Federal Domestic Assistance No. 83.516, Disaster Assistance.)

Wallace E. Stickney,

Director.

[FR Doc. 92-20996 Filed 8-31-92; 8:45 am]

BILLING CODE 6718-02-M

Meeting; FEMA Security Practices Board of Review

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Notice of meeting.

SUMMARY: In accordance with Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. app. 2, FEMA announces the following committee meeting, portions of which may be closed:

Name: FEMA Security Practices Board of Review.

Dates of meeting: Friday, August 28, 1992 and Friday, September 4, 1992.

Place: Federal Emergency Management Agency, John W. Macy, Jr. Conference Room, room 829, 500 C Street, SW., Washington, DC 20472.

Times: 9 a.m. to 4 p.m. on both days.

Proposed agenda: Both days, discuss and prepare final report.

FOR FURTHER INFORMATION CONTACT:

Dirk J. Vande Beek, Office of the Director, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646-3923.

SUPPLEMENTARY INFORMATION: The Review Board must complete its review and report by September 11, 1992. In view of this time limit and owing to the complex, sensitive, and urgent nature of FEMA security matters, less than 15 days notice of the meeting is given, under 41 CFR 101-6.1015(b)-(2).

The meeting will be open to the public with approximately 10 seats available on a first-come, first-served basis. Members of the general public who plan to attend the meeting should contact the Office of the Director, Federal

Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646-3923 on or before Friday, August 28, 1992 or Wednesday, September 2, 1992.

The Director has determined that portions of the Board meeting may have to be closed to the public in accordance with section 10(d) of the Federal Advisory Committee Act, 5 U.S.C. app. 2, and 5 U.S.C. 552b(c), because discussions may (1) disclose matters that are specifically authorized under criteria established by an Executive order to be kept secret in the interests of national defense, (2) relate solely to the internal personnel rules and practices of an agency, and (3) disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of privacy.

Minutes of the meeting (minus those portions of the meeting which may be closed to the public) will be prepared and will be available for public viewing in the Office of the Director, Federal Emergency Management Agency, room 828, 500 C Street, SW., Washington, DC 20472. Copies of the minutes will be available upon request 30 days after the meeting.

Dated: August 26, 1992.

Wallace E. Stickney,

Director.

[FR Doc. 92-20993 Filed 8-31-92; 8:45 am]

BILLING CODE 6718-01-M

FEDERAL MARITIME COMMISSION

San Francisco Port Commission/ Evergreen Marine Corp. et al.; Agreement(s) Filed

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, DC Office of the Federal Maritime Commission, 800 North Capitol Street, NW., 9th Floor. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within 10 days after the date of the Federal Register in which this notice appears. The requirements for comments are found in § 572.603 of title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 224-200374-001.

Title: San Francisco Port Commission/Evergreen Marine Corp.

(Taiwan) Ltd., Marine Terminal Agreement.

Parties: San Francisco Port Commission ("Port"), Evergreen Marine Corp. (Taiwan) Ltd. ("Evergreen").

Synopsis: The Agreement allows Evergreen to receive fifty percent of all demurrage collected by the Port on cargoes subject to the Agreement.

Agreement No.: 224-200403-002.

Title: Georgia Ports Authority/ Safbank Line, Ltd.

Parties: The Georgia Ports Authority, Safbank Line, Ltd.

Synopsis: The Agreement extends the term of the basic Agreement for another six month period from September 3, 1992 through March 3, 1993.

Agreement No.: 224-200695.

Title: Port of Houston Authority/ Houston Deepwater, Inc., Marine Terminal Lease Agreement.

Parties: The Port of Houston Authority ("Port") Houston Deepwater, Inc.

Filing Agent: Robert J. Stefani, Jr., Esq. Robins, Kaplan, Miller & Ciresi Attorneys At Law, Suite 1200, 1801 K Street, NW., Washington, DC 20006-1301.

Synopsis: The Agreement is a marine terminal lease agreement whereby the Port will lease approximately 30.9 acres of land to Houston Deepwater, Inc. The term of the Agreement is for four years.

Dated: August 26, 1992.

By Order of the Federal Maritime Commission.

[FR Doc. 92-20945 Filed 8-31-92; 8:45 am]

BILLING CODE 6730-01-M

Ocean Freight Forwarder License Applicants

Notice is hereby given that the following applicants have filed with the Federal Maritime Commission applications for licenses as ocean freight forwarders pursuant to section 19 of the Shipping Act of 1984 (46 U.S.C. app. 1718 and 46 CFR part 510).

Persons knowing of any reason why any of the following applicants should not receive a license are requested to contact the Office of Freight Forwarders, Federal Maritime Commission, Washington, DC 20573.

Protocol International Company, 500 E. Carson Plaza Drive, #102, Carson, CA 90746, Luis R. Hallon, Sole Proprietor. Columbia Shipping Inc., 1164 Cherry Ave., San Bruno, CA 94066, Officers: Phillip Harrison, President/ Stockholder, Ronald McDonald, Vice President/Stockholder, Kerry McDonald, Vice President/ Stockholder, Diane Weldon, Vice

President, Lawrence Bauer, Secretary/Stockholder.

Fast Forward Transportation Services, Inc., 9777 Satellite Blvd., Suite 220, Orlando, FL 32837. Officer: John P. Jordan, President.

Davis Freight Systems, Inc., 7722 N.W. 56 Street, Miami, FL 33166. Officer: Larry E. Davis, President/Stockholder.

SAI Worldwide Inc., 175 West 13th Street, New York, NY 10011. Officers: Elizabeth de Martino, President/Treasurer, John M. Lynn, Vice President/Secretary.

Total Transport Inc., 7749 E. 11th Street, Tulsa, OK 74112. Officers: Clifford Randal Honeycutt, President/C.E.O., Elizabeth Ann Honeycutt, Vice President/Treasurer.

F. Angel & Associates Inc., 15575 Miami Lakeway North, #102, Miami Lakes, FL 33014. Officer: Fernando Angel, President.

Fashion Distribution Services, Inc., 148-08 Guy R. Brewer Blvd., Jamaica, NY 11434. Officers: Anthony Turrigiano, President, Gabriele Gaetani, Director, Filippo Occaso, Secretary/Treasurer, Carl Mussa, Vice President.

Long Transportation Services, Inc., 5604 Departure Drive, Raleigh, N.C. 27604. Officers: L. Duane Long, Pres./Treas./Dir./Stockh., Ernest H. Beauregard, Asst. Vice President.

Dated: August 26, 1992.
By the Federal Maritime Commission.

Joseph C. Polking,
Secretary.

[FR Doc. 92-29837 Filed 8-31-92; 8:45 am]
BILLING CODE 6730-01-M

FEDERAL RESERVE SYSTEM

Central-State Bancorp, Inc., et al.; Notice of Applications to Engage de novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for

processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 25, 1992.

A. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Central-State Bancorp, Inc.*, Frankfort, Michigan; to engage *de novo* through its subsidiary, Central State Service Corp., Beulah, Michigan, in the making and selling of fixed rate mortgages in the secondary mortgage market pursuant to § 225.25(b)(1) of the Board's Regulation Y.

2. *Kennedy Bancshares, Inc.*, Bancroft, Iowa; to engage *de novo* in making commercial and agricultural loans, residential real estate mortgage loans and commercial and agricultural real estate mortgage loans pursuant to § 225.25(b)(1) of the Board's Regulation Y. These activities will be conducted in the State of Iowa.

Board of Governors of the Federal Reserve System, August 26, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-20961 Filed 8-31-92; 8:45 am]

BILLING CODE 6210-01-F

Hawkeye Bancorporation, et al.; Formations of; Acquisitions by; and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank

holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Unless otherwise noted, comments regarding each of these applications must be received not later than September 25, 1992.

A. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Hawkeye Bancorporation*, Des Moines, Iowa; to merge with Jasand, Inc., Cedar Rapids, Iowa, and thereby indirectly acquire City National Bank of Cedar Rapids, Cedar Rapids, Iowa.

B. Federal Reserve Bank of Kansas City (John E. Yorke, Senior Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *Nichols Hills Bancorporation, Inc.*, Oklahoma City, Oklahoma; to acquire 100 percent of the voting shares of Leadership Bank, N.A., Oklahoma City, Oklahoma.

C. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 400 South Akard Street, Dallas, Texas 75222:

1. *BancTexas Group, Inc.*, Dallas, Texas; to acquire 100 percent of the voting shares of First Bank/Las Colinas, Irving, Texas.

Board of Governors of the Federal Reserve System, August 26, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-20963 Filed 8-31-92; 8:45 am]

BILLING CODE 6210-01-F

Metrocorp, Inc. Employee Stock Ownership Plan; Change in Bank Control Notice; Acquisition of Shares of Banks or Bank Holding Companies

The notificant listed below has applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank

holding company. The factors that are considered in acting on notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notice is available for immediate inspection at the Federal Reserve Bank indicated. Once the notice has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for the notice or to the offices of the Board of Governors. Comments must be received not later than September 21, 1992.

A. Federal Reserve Bank of Chicago
(David S. Epstein, Vice President) 230
South LaSalle Street, Chicago, Illinois
60690:

1. *Metrocorp, Inc. Employee Stock Ownership Plan*, East Moline, Illinois; to acquire 22.87 percent of the voting shares of Metrocorp, Inc., East Moline, Illinois, and thereby indirectly acquire Metrobank, East Moline, Illinois.

Board of Governors of the Federal Reserve System, August 26, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-20962 Filed 8-31-92; 8:45 am]

BILLING CODE 6210-01-F

FOR FURTHER INFORMATION CONTACT:
Nancy Warder, FTC/S-4002,
Washington, DC 20580. (202) 326-3048.

SUPPLEMENTARY INFORMATION: On Tuesday, September 17, 1991, there was published in the *Federal Register*, 56 FR 47083, a proposed consent agreement with analysis in the Matter of Bertolli USA, Inc., for the purpose of soliciting public comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

Comments were filed and considered by the Commission. The Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to cease and desist, as set forth in the proposed consent agreement, in disposition of this proceeding.

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interprets or applies sec. 5, 38 Stat. 719, as amended; 15 U.S.C. 45)

Donald S. Clark,
Secretary.

[FR Doc. 92-20970 Filed 8-31-92; 8:45 am]

BILLING CODE 6750-01-M

[Dkt. 9223]

Campbell Soup Company; Prohibited Trade Practices, and Affirmative Corrective Actions

AGENCY: Federal Trade Commission.

ACTION: Consent Order.

SUMMARY: In settlement of alleged violations of federal law prohibiting unfair acts and practices and unfair methods of competition, this consent order requires, among other things, a Camden, N.J., based company to disclose in future advertisements that directly or by implication mention heart disease—in connection with soups containing significant amounts of sodium—both the sodium content of a serving of such soup and the recommended maximum daily limit on sodium intake. Respondent also is prohibited from representing a connection between any soup and a reduction in the risk of heart disease, unless such representations are substantiated by competent and reliable scientific or medical evidence.

DATES: Complaint issued January 25, 1989. Order issued August 18, 1992.¹

¹ Copies of the Complaint, the Decision and Order, and the statement of Commissioner Azcuenaga are available from the Commission's Public Reference Branch, H-130, 6th Street & Pennsylvania Avenue, NW., Washington, DC 20580.

FOR FURTHER INFORMATION CONTACT:
Lee Peeler or Nancy Warder, FTC/S-4002, Washington, DC 20580. (202) 326-3090 or 326-3048.

SUPPLEMENTARY INFORMATION: On Thursday, April 18, 1991, there was published in the *Federal Register*, 56 FR 15880, a proposed consent agreement with analysis in the Matter of Campbell Soup Company, for the purpose of soliciting public comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

Comments were filed and considered by the Commission. The Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to cease and desist, as set forth in the proposed consent agreement, in disposition of this proceeding.

Authority: Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interprets or applies sec. 5, 38 Stat. 719, as amended; 15 U.S.C. 45, 52.

Donald S. Clark,
Secretary.

[FR Doc. 92-20968 Filed 8-31-92; 8:45 am]

BILLING CODE 6750-01-M

[Dkt. C-3395]

Pacific Rice Products, Inc.; Prohibited Trade Practices, and Affirmative Corrective Actions

AGENCY: Federal Trade Commission.

ACTION: Consent order.

SUMMARY: In settlement of alleged violations of federal law prohibiting unfair acts and practices and unfair methods of competition, this consent order prohibits, among other things, a California company from misrepresenting the contents, validity, results, conclusions or interpretations of any test or study; and from representing that any food produces any health benefit, unless the respondent possesses and relies upon competent and reliable scientific evidence to substantiate the representation.

DATES: Complaint and Order issued August 17, 1992.¹

FOR FURTHER INFORMATION CONTACT:
Phillip Broyles, Cleveland Regional Office, Federal Trade Commission, 668 Euclid Ave., suite 520-A, Cleveland, OH 44114. (216) 522-4207.

¹ Copies of the Complaint and the Decision and Order are available from the Commission's Public Reference Branch, H-130, 6th Street & Pennsylvania Avenue, NW., Washington, DC 20580.

FEDERAL TRADE COMMISSION

[Dkt. C-3396]

Bertolli USA, Inc.; Prohibited Trade Practices, and Affirmative Corrective Actions

AGENCY: Federal Trade Commission.

ACTION: Consent order.

SUMMARY: In settlement of alleged violations of federal law prohibiting unfair acts and practices and unfair methods of competition, this consent order prohibits, among other things, a New Jersey-based company from misrepresenting the validity, results, conclusions or interpretations of any test or study; and from representing that olive oil or any other edible oil produces any health benefits, such as reducing blood pressure and blood sugar, unless the respondent possesses and relies upon competent and reliable scientific evidence that substantiates the representation.

DATES: Complaint and Order issued August 17, 1992.¹

¹ Copies of the Complaint and the Decision and Order are available from the Commission's Public Reference Branch, H-130, 6th Street & Pennsylvania Avenue, NW., Washington, DC 20580.

SUPPLEMENTARY INFORMATION: On Tuesday, September 17, 1991, there was published in the *Federal Register*, 56 FR 47086, a proposed consent agreement with analysis in the Matter of Pacific Rice Products, Inc., for the purpose of soliciting public comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

Comments were filed and considered by the Commission. The Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to cease and desist, as set forth in the proposed consent agreement, in disposition of this proceeding.

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interprets or applies sec. 5, 38 Stat. 719, as amended; 15 U.S.C. 45, 52)

Donald S. Clark,

Secretary.

[FR Doc. 92-20971 Filed 8-31-92; 8:45 am]

BILLING CODE 6750-01-M

[Dkt. C-3391]

The Vons Companies, Inc.; Prohibited Trade Practices, and Affirmative Corrective Actions

AGENCY: Federal Trade Commission.

ACTION: Consent order.

SUMMARY: In settlement of alleged violations of federal law prohibiting unfair acts and practices and unfair methods of competition, this consent order requires, among other things, a California-based national grocery chain to sell its Madonna Road supermarket in San Luis Obispo to an FTC-approved purchaser within twelve months or else consent to the appointment of a Commission-approved trustee to divest the property. The respondent is also required, for a period of 10 years, to obtain FTC approval before making similar acquisitions.

DATES: Complaint and Order issued August 7, 1992.¹

FOR FURTHER INFORMATION CONTACT: Steven Newborn, FTC/S-2308, Washington, DC 20580. (202) 326-2815; or Paul Roark, Los Angeles Regional Office, Federal Trade Commission, 11000 Wilshire Blvd., suite 13209, Los Angeles, CA 90024. (310) 575-7890.

¹ Copies of the Complaint, the Decision and Order, and Commissioner Azcuenaga's statement are available from the Commission's Public Reference Branch, H-130, 6th Street & Pennsylvania Avenue, NW., Washington, DC 20580.

SUPPLEMENTARY INFORMATION: On Wednesday, June 3, 1992, there was published in the *Federal Register*, 57 FR 23410, a proposed consent agreement with analysis in the Matter of The Vons Companies, Inc., for the purpose of soliciting public comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

No comments having been received, the Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to divest, as set forth in the proposed consent agreement, in disposition of this proceeding.

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interpret or apply sec. 5, 38 Stat. 719, as amended; sec. 7, 38 Stat. 731, as amended; 15 U.S.C. 45, 18)

Donald S. Clark,

Secretary.

[FR Doc. 92-20969 Filed 8-31-92; 8:45 am]

BILLING CODE 6750-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Alcohol, Drug Abuse, and Mental Health Administration

Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies and Laboratories That Have Withdrawn From the Program

AGENCY: National Institute on Drug Abuse, ADAMHA, HHS.

ACTION: Notice.

SUMMARY: The Department of Health and Human Services notifies Federal agencies of the laboratories currently certified to meet standards of Subpart C of Mandatory Guidelines for Federal Workplace Drug Testing Programs (53 FR 11979, 11986). A similar notice listing all currently certified laboratories will be published during the first week of each month, and updated to include laboratories which subsequently apply for and complete the certification process. If any listed laboratory's certification is totally suspended or revoked, the laboratory will be omitted from updated lists until such time as it is restored to full certification under the Guidelines.

If any laboratory has withdrawn from the National Laboratory Certification Program during the past month, it will be identified as such at the end of the current list of certified laboratories, and will be omitted from the monthly listing thereafter.

FOR FURTHER INFORMATION CONTACT: Denise L. Goss, Program Assistant, Drug Testing Section, Division of Applied Research, National Institute on Drug Abuse, room 9-A-53, 5600 Fishers Lane, Rockville, Maryland 20857; tel.: (301) 443-6014.

SUPPLEMENTARY INFORMATION: Mandatory Guidelines for Federal Workplace Drug Testing were developed in accordance with Executive Order 12564 and section 503 of Pub. L. 100-71. Subpart C of the Guidelines, "Certification of Laboratories Engaged in Urine Drug Testing for Federal Agencies," sets strict standards which laboratories must meet in order to conduct urine drug testing for Federal agencies. To become certified an applicant laboratory must undergo three rounds of performance testing plus an on-site inspection. To maintain that certification a laboratory must participate in an every-other-month performance testing program plus periodic, on-site inspections.

Laboratories which claim to be in the applicant stage of NIDA certification are not to be considered as meeting the minimum requirements expressed in the NIDA Guidelines. A laboratory must have its letter of certification from HHS/NIDA which attests that it has met minimum standards.

In accordance with Subpart C of the Guidelines, the following laboratories meet the minimum standards set forth in the Guidelines:

- AccuTox Analytical Laboratories, 427 Fifth Avenue, N.W., P.O. Box 770, Attalla, AL 35954-0770, 205-538-0012/800-247-3893.
- Aegis Analytical Laboratories, Inc., 624 Grassmere Park Road, Suite 21, Nashville, TN 37211, 615-331-5300.
- Alabama Reference Laboratories, Inc., 543 South Hull Street, Montgomery, AL 36103, 800-541-4931/205-263-5745.
- Allied Clinical Laboratories, 201 Plaza Boulevard, Hurst, TX 76053, 817-282-2257.
- American Medical Laboratories, Inc., 11091 Main Street, P.O. Box 188, Fairfax, VA 22030, 703-691-9100.
- Associated Pathologists Laboratories, Inc., 4230 South Burnham Avenue, Suite 250, Las Vegas, NV 89119-5412, 702-733-7866.
- Associated Regional and University Pathologists, Inc. (ARUP), 500 Chipeta Way, Salt Lake City, UT 84108, 801-583-2787.
- Baptist Medical Center—Toxicology Laboratory, 9601 I-630, Exit 7, Little Rock, AR 72205-7299, 501-227-2783 (formerly: Forensic Toxicology Laboratory Baptist Medical Center).
- Bayshore Clinical Laboratory, 4555 W. Schroeder Drive, Brown Deer, WI 53223, 414-355-4444/800-877-7018.
- Bellin Hospital—Toxicology Laboratory, 215 N. Webster Ave., Green Bay, WI 54301, 414-433-7485.

- Bioran Medical Laboratory, 415 Massachusetts Avenue, Cambridge, MA 02139, 617-547-8900.
- California Toxicology Services, 1925 East Dakota Avenue, Suite 206, Fresno, CA 93726, 209-221-5655/800-448-7600.
- Cedars Medical Center, Department of Pathology, 1400 Northwest 12th Avenue, Miami, FL 33136, 305-325-5810.
- Clinical Pathology Facility, Inc., 711 Bingham Street, Pittsburgh, PA 15203, 412-488-7500.
- Clinical Reference Lab, 11850 West 85th Street, Lenexa, KS 66214, 800-445-6917.
- CompuChem Laboratories, Inc., A Subsidiary of Roche Biomedical Laboratory, 3308 Chapel Hill/Nelson Hwy., Research Triangle Park, NC 27709, 919-549-8263/800-833-3984.
- CompuChem Laboratories, Special Division, 3308 Chapel Hill/Nelson Hwy., Research Triangle Park, NC 27709, 919-549-8263.
- Cox Medical Centers, Department of Toxicology, 1423 North Jefferson Avenue, Springfield, MO 65802, 800-876-3652/417-836-3093.
- Damon Clinical Laboratories, 140 East Ryan Road, Oak Creek, WI 53154, 800-638-1100 (name changed: formerly Chem-Bio Corporation; CBC Clinilab).
- Damon Clinical Laboratories, 8300 Esters Blvd., Suite 900, Irving, TX 75063, 214-929-0535.
- Doctors & Physicians Laboratory, 801 East Dixie Avenue, Leesburg, FL 32748, 904-787-9006.
- Drug Labs of Texas, 15201 I-10 East, Suite 125, Channelview, TX 77530, 713-457-3784.
- DrugScan, Inc., P.O. Box 2969, 1119 Mearns Road, Warminster, PA 18974, 215-674-9310.
- Eagle Forensic Laboratory, Inc., 950 North Federal Highway, Suite 308, Pompano Beach, FL 33062, 305-946-4324.
- Eastern Laboratories, Ltd., 95 Seaview Boulevard, Port Washington, NY 11050, 516-825-9800.
- ElSohly Laboratories, Inc., 1215-1/2 Jackson Ave., Oxford, MS 38655, 601-236-2609.
- Employee Health Assurance Group, 405 Alderson Street, Schofield, WI 54476, 800-627-8200 (name change: formerly Alpha Medical Laboratory, Inc.).
- General Medical Laboratories, 36 South Brooks Street, Madison, WI 53715, 608-267-6267.
- Harris Medical Laboratory, 7606 Pebble Drive, Fort Worth, TX 76118, 817-595-0294.
- Harrison & Associates Forensic Laboratories, 606 N. Weatherford, P.O. Box 2788, Midland, TX 79702, 800-725-3784/915-687-6877.
- HealthCare/Preferred Laboratories, 24451 Telegraph Road, Southfield, MI 48034, 800-328-4142 (inside MI)/800-225-9414 (outside MI).
- Hermann Hospital Toxicology Laboratory, Hermann Professional Building, 6410 Fannin, Suite 354, Houston, TX 77030, 713-793-6080.
- IHC Laboratory Services Forensic Toxicology, 930 North 500 West, Suite E, Provo, UT 84604, 800-967-9766.
- Laboratory of Pathology of Seattle, Inc., 1229 Madison St., Suite 500, Nordstrom Medical Tower, Seattle, WA 98104, 206-386-2672.
- Laboratory Specialists, Inc., 113 Jarrell Drive, Belle Chasse, LA 70037, 504-392-7961.
- Marshfield Laboratories, 1000 North Oak Avenue, Marshfield, WI 54449, 715-389-3734.
- Mayo Medical Laboratories, 200 S.W. First Street, Rochester, MN 55905, 507-284-3631.
- Med-Chek Laboratories, Inc., 4900 Perry Highway, Pittsburgh, PA 15229, 412-931-7200.
- MedExpress/National Laboratory Center, 4022 Willow Lake Boulevard, Memphis, TN 38175, 901-795-1515.
- MedTox Bio-Analytical, a Division of MedTox Laboratories, Inc., 9176 Independence Avenue, Chatsworth, CA 91311, 818-718-0115/800-331-8670 (outside CA)/800-464-7081 (inside CA) (name changed: formerly Laboratory Specialists, Inc.; Abused Drug Laboratories).
- MedTox Bio-Analytical, a Division of MedTox Laboratories, Inc., 2356 North Lincoln Avenue, Chicago, IL 60614, 312-880-6900 (name changed: formerly Bio-Analytical Technologies).
- MedTox Laboratories, Inc., 402 W. County Road D, St. Paul, MN 55112, 800-832-3244/612-636-7466.
- Methodist Hospital of Indiana, Inc., Department of Pathology and Laboratory Medicine, 1701 N. Senate Boulevard, Indianapolis, IN 46202, 317-929-3587.
- Methodist Medical Center Toxicology Laboratory, 221 N.E. Glen Oak Avenue, Peoria, IL 61636, 800-752-1835/309-671-5199.
- MetPath, Inc., 1355 Mittel Boulevard, Wood Dale, IL 60191, 708-595-3888.
- MetPath, Inc., One Malcolm Avenue, Teterboro, NJ 07608, 201-393-5000.
- MetWest-BPL Toxicology Laboratory, 18700 Oxnard Street, Tarzana, CA 91356, 800-492-0800/818-343-8191.
- National Center for Forensic Science, 1901 Sulphur Spring Road, Baltimore, MD 21227, 410-536-1485 (name changed: formerly Maryland Medical Laboratory, Inc.).
- National Drug Assessment Corporation, 5419 South Western, Oklahoma City, OK 73109, 800-749-3784 (name changed: formerly Med Arts Lab).
- National Health Laboratories Incorporated, 2540 Empire Drive, Winston-Salem, NC 27103-6710, 919-760-4620/800-334-8627 (outside NC)/800-642-0894 (inside NC).
- National Health Laboratories Incorporated, 75 Rod Smith Place, Cranford, NJ 07016-2843, 908-272-2511.
- National Health Laboratories Incorporated, d.b.a. National Reference Laboratory, Substance Abuse Division, 1400 Donelson Pike, Suite A-15, Nashville, TN 37217, 615-360-3992/800-800-4522.
- National Health Laboratories Incorporated, 13900 Park Center Road, Herndon, VA 22071, 703-742-3100/800-572-3734 (inside VA)/800-336-0391 (outside VA).
- National Psychopharmacology Laboratory, Inc., 9320 Park W. Boulevard, Knoxville, TN 37923, 800-251-9492.
- National Toxicology Laboratories, Inc., 1100 California Avenue, Bakersfield, CA 93304, 805-322-4250.
- Nichols Institute Substance Abuse Testing (NISAT), 8985 Balboa Avenue, San Diego, CA 92123, 800-446-4728/619-694-5050 (name changed: formerly Nichols Institute).
- Northwest Toxicology, Inc., 1141 E. 3900 South, Salt Lake City, UT 84124, 800-322-3361.
- Occupational Toxicology Laboratories, Inc., 2002 20th Street, Suite 204A, Kenner, LA 70062, 504-465-0751.
- Oregon Medical Laboratories, P.O. Box 972, 722 East 11th Avenue, Eugene, OR 97440-0972, 503-687-2134.
- Parke DeWatt Laboratories, Division of Comprehensive Medical Systems, Inc., 1810 Frontage Rd., Northbrook, IL 60062, 708-480-4680.
- Pathology Associates Medical Laboratories, East 11604 Indiana, Spokane, WA 99206, 509-926-2400.
- PDLA, Inc. (Precision), 5 Industrial Park Drive, Oxford, MS 38655, 601-236-5600/800-237-7352.
- PDLA, Inc. (Princeton), 100 Corporate Court, So. Plainfield, NJ 07080, 908-769-8500/800-237-7352.
- PharmChem Laboratories, Inc., 1505-A O'Brien Drive, Menlo Park, CA 94025, 415-328-6200/800-446-5177.
- Poisonlab, Inc., 7272 Clairemont Mesa Road, San Diego, CA 92111, 619-279-2600.
- Precision Analytical Laboratories, Inc., 13300 Blanco Road, Suite #150, San Antonio, TX 78218, 512-493-3211.
- Puckett Laboratory, 4200 Mamie Street, Hattiesburg, MS 39402, 601-264-3856/800-844-8378.
- Regional Toxicology Services, 15305 N.E. 40th Street, Redmond, WA 98052, 206-882-3400.
- Resource One, Inc., Seven Pointe Circle, Greenville, SC 29615, 803-233-5639.
- Roche Biomedical Laboratories, 1801 First Avenue South, Birmingham, AL 35233, 205-581-4170.
- Roche Biomedical Laboratories, 1957 Lakeside Parkway, Suite 542, Tucker, GA 30084, 404-939-4811.
- Roche Biomedical Laboratories, Inc., 1120 Stateline Road, Southaven, MS 38671, 601-342-1286.
- Roche Biomedical Laboratories, Inc., 69 First Avenue, Raritan, NJ 08869, 800-437-4986.
- Scott & White Drug Testing Laboratory, 600 S. 25th Street, Temple, TX 76704, 800-749-3788.
- S.E.D. Medical Laboratories, 500 Walter NE, Suite 500, Albuquerque, NM 87102, 505-848-8800.
- Sierra Nevada Laboratories, Inc., 888 Willow Street, Reno, NV 89502, 800-648-5472.
- SmithKline Beecham Clinical Laboratories, 7600 Tyrone Avenue, Van Nuys, CA 91045, 818-376-2520.
- SmithKline Beecham Clinical Laboratories, 3175 Presidential Drive, Atlanta, GA 30340, 404-934-9205 (name changed: formerly SmithKline Bio-Science Laboratories).
- SmithKline Beecham Clinical Laboratories, 506 E. State Parkway, Schaumburg, IL 60173, 708-885-2010 (name changed: formerly International Toxicology Laboratories).
- SmithKline Beecham Clinical Laboratories, 11636 Administration Drive, St. Louis, MO 63146, 314-567-3905.
- SmithKline Beecham Clinical Laboratories, 400 Egypt Road, Norristown, PA 19403, 800-523-5447 (name changed: formerly SmithKline Bio-Science Laboratories).

SmithKline Beecham Clinical Laboratories,
8000 Sovereign Row, Dallas, TX 75247, 214-
638-1301 (name changed: formerly
SmithKline Bio-Science Laboratories).
South Bend Medical Foundation, Inc., 530 N.
Lafayette Boulevard, South Bend, IN 46601,
219-234-4176.

Southgate Medical Services, Inc., 21100
Southgate Park Boulevard, Cleveland, OH
44137-3054, 800-338-0166 (outside OH)/
800-362-8913 (inside OH) (name changed:
formerly Southgate Medical Laboratory).
St. Anthony Hospital (Toxicology
Laboratory), P.O. Box 205, 1000 N. Lee
Street, Oklahoma City, OK 73102, 405-272-
7052.

St. Louis University Forensic Toxicology
Laboratory, 1205 Carr Lane, St. Louis, MO
63104, 314-577-8628.

Toxicology & Drug Monitoring Laboratory,
University of Missouri Hospital & Clinics,
301 Business Loop 70 West, Suite 208,
Columbia, MO 65203, 314-882-1273.

Toxicology Testing Service, Inc., 5426 N.W.
79th Avenue, Miami, FL 33166, 305-593-
2260.

The following laboratory voluntarily
withdrew from the National Laboratory
Certification Program:

Center for Human Toxicology, 417 Wakara
Way, Room 290, University Research Park,
Salt Lake City, UT 84108, 801-581-5117.

Richard A. Millstein,

Acting Director, National Institute on Drug
Abuse.

[FR Doc. 92-20912 Filed 8-31-92; 8:45 am]

BILLING CODE 4160-20-M

National Institute of Mental Health; Meetings

Pursuant to Public Law 92-463, notice
is hereby given of the meeting of the
National Advisory Mental Health
Council for September 1992.

The Council will be performing review
of applications for Federal assistance;
therefore, a portion of this meeting will
be closed to the public as determined by
the Acting Administrator, ADAMHA, in
accordance with 5 U.S.C. 552b(c)(6) and
5 U.S.C. app. 2 10(d).

Summaries of the meeting and a roster
of committee members may be obtained
from: Ms. Joanna L. Kieffer, NIMH
Committee Management Officer,
Alcohol, Drug Abuse, and Mental Health
Administration, Parklawn Building,
room 9-105, 5600 Fishers Lane,
Rockville, MD 20857 (telephone: 301-
443-4333).

Substantive program information may
be obtained from the contact whose
name, room number, and telephone
number is listed below.

Committee Name: National Advisory
Mental Health Council.

Meeting Date: September 14-15, 1992.

Place: September 14—Conference Rooms C
and H, Parklawn Building, 5600 Fishers Lane,
Rockville, MD 20857.

September 15—Wilson Hall, Building 1,
National Institutes of Health, 9000 Rockville
Pike, Bethesda, MD 20892.

Closed: September 14, 8:30 a.m.—12:30 p.m.

Open: September 14, 1:30 p.m.—

Adjournment on September 15.

Contact: Carolyn Strete, Ph.D., Room 9-105,
Parklawn Building, Telephone (301) 443-3367.

Dated: August 26, 1992.

Peggy W. Cockrill,

Committee Management Officer, Alcohol,
Drug Abuse, and Mental Health
Administration.

[FR Doc. 92-20937 Filed 8-31-92; 8:45 am]

BILLING CODE 4160-20-M

Centers for Disease Control

[Program Announcement 302]

FY 1993 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Surveillance Cooperative Agreements

Introduction

The Centers for Disease Control
(CDC), the Nation's prevention agency,
announces the availability of fiscal year
(FY) 1993 funds for cooperative
agreements for human
immunodeficiency virus (HIV)/acquired
immunodeficiency syndrome (AIDS)
surveillance. These activities are
intended to continue and strengthen
HIV/AIDS surveillance programs;
evaluate and develop alternative HIV/
AIDS surveillance methods; and
measure and evaluate the extent of
HIV/AIDS incidence and prevalence
throughout the United States and its
territories. These programs will provide
information for public policy and for
targeting strategies for HIV prevention
and treatment programs, including
improving linkages to medical and
social support services.

Cooperative agreements will be
awarded for three major programs:

A. HIV/AIDS Surveillance

1. Surveillance of AIDS (AIDS)
2. Adult/Adolescent HIV Infection
Surveillance (AAHIS)
3. Pediatric HIV Infection Surveillance
(PHIS)

B. Expanded Initiatives for HIV/AIDS Surveillance

1. Adult/Adolescent Spectrum of Disease
(ASD)
2. Supplement to HIV/AIDS Surveillance
(SHAS)
3. National Death Index (NDI)

C. HIV Serosurveillance

1. Survey in Childbearing Women (SCBW)
2. Ongoing Unlinked Surveys (US)
3. New Time-limited Surveys and Studies
(TLS)

Applicants may request funds for
more than one program under this
announcement. Each request, however,

must be complete as it will be evaluated
separately without reference to any
other program.

The Public Health Service (PHS) is
committed to achieving the health
promotion and disease prevention
objectives of Healthy People 2000, a
PHS-led national activity to reduce
morbidity and mortality and improve the
quality of life. This announcement is
related to the priority area of HIV
infection. (For ordering a copy of
Healthy People 2000, see the section
Where To Obtain Additional
Information.)

Authority

This program is authorized under
sections 301(a) (42 U.S.C. 241(a)), 311 (42
U.S.C. 243), and 317(k)(3) (42 U.S.C.
247b(k)(3)) of the Public Health Service
Act, as amended. Application program
regulations are found in 42 CFR Part
52—Grants for Research Projects.

Eligible Applicants

Assistance will be provided only to
the official public health departments of
states or their bona fide agents or
instrumentalities. This includes the
District of Columbia, American Samoa,
the Commonwealth of Puerto Rico, the
Virgin Islands, the Federated States of
Micronesia, Guam, the Northern
Mariana Islands, the Republic of the
Marshall Islands, the Republic of Palau,
and federally recognized Indian tribal
governments.

A. HIV/AIDS Surveillance

Surveillance of AIDS; Adult/Adolescent
HIV Infection Surveillance; Pediatric
HIV Infection Surveillance

Eligible applicants are official health
agencies of the states; the cities of
Chicago, Houston, Philadelphia, New
York, San Francisco; and the County of
Los Angeles.

Eligible applicants for Adult/
Adolescent HIV Infection Surveillance
must document that reporting of HIV
infection by name or other unique
identifier is required by statute or law,
and that such requirements are
scheduled for implementation by
January 1, 1993. All applicants for
Adult/Adolescent HIV Infection
Surveillance will be expected to
establish pediatric HIV infection
reporting activities.

For separate funding under the
Pediatric HIV Infection Surveillance
component, applicants must meet the
HIV reporting requirement described
above or not be prohibited from
receiving reports of HIV infection in
children by current statute or law.

B. Expanded Initiatives for HIV/AIDS Surveillance**1. Maintenance of Existing ASD, SHAS, and NDI Components**

Eligible applicants for competing continuation funding of the Adult Spectrum of Disease (ASD), Supplement to HIV/AIDS Surveillance (SHAS), and National Death Index (NDI) projects are the official state and local health agencies who are current recipients of funding in the 1991 Expanded Initiatives and the Evaluation of Surveillance of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection Cooperative Agreements.

2. Development of New ASD and SHAS Programs

Eligible applicants for new funding for the ASD and SHAS projects are official health agencies of the states; the cities of Chicago, Houston, Philadelphia, New York, San Francisco; and the County of Los Angeles; who are not current recipients of funding for the ASD and SHAS projects. New projects for NDI are not solicited.

C. HIV Serosurveillance**1. Survey in Childbearing Women**

Eligible applicants for new and competing continuation funding for the survey in childbearing women and the evaluation of the effects of prenatal and perinatal HIV testing policies are the official public health agencies of states, the District of Columbia, and the Commonwealth of Puerto Rico.

2. Ongoing Unlinked Surveys and New Time-Limited Surveys

Eligible applicants for ongoing Unlinked Surveys and new Time-limited Surveys and Studies are those state and local public health agencies who are currently participating in unlinked, urban, clinic-based surveys in 44 sentinel cities.

Eligible applicants of sentinel hospital serosurveys are those public health agencies who are funded for these projects under the current HIV/AIDS Surveillance cooperative agreement.

Availability of Funds

Approximately \$48 million will be available in FY 1993 to fund approximately 65 awards. Awards are expected to range from \$6,000 to \$3,500,000. The awards will begin on or about January 1, 1993, and will be for a 12-month budget period within a project period of up to three years. Continuation awards within the project period will be made on the basis of satisfactory progress and availability of funds.

Funding estimates for the components listed below may vary and are subject to change.

A. HIV/AIDS Surveillance

Approximately \$25.1 million will be available for AIDS Surveillance and Adult, Adolescent, and Pediatric HIV Surveillance.

1. Surveillance of AIDS (AIDS)

Approximately \$20 million will be available for 65 new and competing continuation projects.

2. Adult/Adolescent HIV Infection Surveillance (AAHIS)

Approximately \$3.6 million will be available for 25 new and competing continuation projects.

3. Pediatric HIV Infection Surveillance (PHIS)

Approximately \$1.5 million will be available for 18 new and competing continuation projects.

B. Expanded Initiatives for HIV/AIDS Surveillance

Approximately \$3.9 million will be available for Expanded Initiatives for HIV/AIDS Surveillance.

1. Adult/Adolescent Spectrum of Disease (ASD)

Approximately \$2.0 million will be available for 8 competing continuation and 2 new projects.

2. Supplement to HIV/AIDS Surveillance (SHAS)

Approximately \$1.2 million will be available for 12 competing continuation and 2 new projects.

3. National Death Index (NDI)

Approximately \$0.7 million will be available for 17 competing continuation projects. Funds are not available for new competing awards for National Death Index projects.

C. HIV Serosurveillance

Approximately \$19.2 million is available for HIV serosurveillance activities.

1. Survey in Childbearing Women (SCBW)

Approximately \$9.1 million will be available for new and competing continuation projects.

2. Ongoing Unlinked Surveys (US) and new Time-limited Serosurveillance Surveys and Studies (TLS)

Approximately \$10.1 million will be available for these surveys and studies in approximately 20 competing continuation projects.

Flexibility

To increase flexibility of this cooperative agreement, recipients may, with prior CDC approval, redirect during 1993 up to 5% of their total award for emerging surveillance/serosurveillance needs. This funding is intended to support focused, one-time projects (e.g., serosurvey in a prison or hospital, evaluation of surveillance completeness, etc.) and to obtain information specifically required for policy decisions or planning prevention programs at the state or local level. Proposals for these projects should not be described in this application but should be submitted during the budget year as funds are identified to support them.

Purpose

The purpose of the HIV/AIDS Surveillance Cooperative Agreement Program is to assist state and local public health departments in (1) monitoring trends in the HIV epidemic and estimating the number of HIV-infected persons diagnosed with severe immunodeficiency; (2) conducting alternative surveillance initiatives that complement or extend information routinely collected through HIV or AIDS surveillance; (3) utilizing HIV/AIDS surveillance and, where available, HIV serosurveillance data collected using CDC protocols to determine populations and areas to which prevention efforts should be especially directed or intensified so that the risk of transmission can be minimized; and (4) detecting and preventing the further spread of HIV infection through developing, implementing, and evaluating serosurveillance surveys and studies, HIV infection surveillance, and selected epidemiologic investigations. The data collected through these activities can assist health departments in developing, targeting, and evaluating education and prevention programs, as well as help the nation monitor the overall patterns and trends of HIV infection and AIDS in the United States. Throughout all these program activities, special emphasis is to be placed on surveillance of HIV/AIDS in racial/ethnic minority populations.

Program Requirements**Cooperative Activities**

In conducting activities to achieve the purpose of this program, the recipients shall be responsible for the activities under A., below, and CDC shall be responsible for conducting activities under B., below.

A. Recipient Activities

The following activities must be planned and conducted in collaboration and coordination with CDC by state and local health departments and, where appropriate, with the participation of:

- Appropriate state and local professional associations;
- Health-care providers and institutions serving, diagnosing, or providing treatment and care for persons with HIV/AIDS including laboratories providing HIV and CD4 lymphocyte testing;
- Organizations that serve persons at increased risk of HIV/AIDS, (e.g., drug use treatment facilities, STD clinics, family planning agencies, maternal and infant care programs, TB clinics, comprehensive hemophilia treatment centers, correctional facilities);
- Community groups and organizations, especially those with a racial and ethnic minority membership and focus; and
- HIV/AIDS service organizations.

Resource/Needs Assessment.

Establish an ongoing assessment process to examine and document current and projected resource requirements for all surveillance efforts. The purpose of the resource/needs assessment is to ensure continued support for current activities and the need for additional program effort. Under section 317 of the PHS Act, direct assistance ("in lieu of cash") may be requested.

The resource/needs assessment should describe how HIV/AIDS surveillance and serosurveillance data are used to direct prevention activities and assess linkages to medical and support services.

1. HIV/AIDS Surveillance

Design, implement, and maintain active surveillance programs for adult, adolescent, and pediatric cases of HIV infection and AIDS meeting the CDC surveillance definitions. Conduct associated epidemiologic investigations to determine trends in incidence of AIDS and prevalence and incidence of HIV infection and identify populations at risk in accordance with CDC guidelines and recommendations. CD4+ lymphocyte counts are routinely recommended in the care of all HIV-infected patients. When available, they should be reported to enhance understanding of the epidemiology of HIV infection and the relationship between clinical manifestations and the severity of HIV-related immunosuppression.

Specific required surveillance activities: a. Design and conduct active surveillance activities to promote optimal reporting of all cases of HIV infection and AIDS (including all pediatric cases) diagnosed in the public health agency's geographic jurisdiction. HIV reporting and other related surveillance activities should complement AIDS case surveillance.

b. Establish liaison with appropriate reporting sources; such as hospitals and clinics, laboratories conducting HIV antibody testing and/or CDR lymphocyte subset analysis, selected physicians (e.g., infectious disease subspecialists), TB clinics, drug treatment facilities, death certificate registries, drug registries (e.g. AZT), and other public health agencies to enhance identification and reporting of cases. Assess yield from reporting sources and direct efforts at these sources based on how effectively they augment active surveillance. Provide periodic feedback to reporting sources.

c. Develop and maintain a secure registry of all reported cases, which includes laboratory, demographic, epidemiologic, and clinical information for individual cases, source of report (e.g., hospital outpatient clinic), and which permits rapid, uniform updates and retrieval of case information for regular and special tabulations and analyses of data. The case registry must be located in an area of limited and controlled access. Procedures must be in place to protect the confidentiality of patient records and the integrity of the surveillance system.

d. Report all cases of HIV infection and AIDS meeting the CDC surveillance definitions to CDC at least monthly.

e. Conduct epidemiologic investigations of cases that have no identified risk factors, including health-care workers who may have been occupationally exposed; selected blood transfusion-related or transplant cases and their donors; and other cases of epidemiologic importance using CDC developed protocols and criteria. Health departments should alert CDC to unusual occurrences identified through these investigations.

f. Augment surveillance through the use of at least one population-based alternative database (e.g., death certificates); and document methods, results, and how the results are being used to re-direct surveillance activities in the semiannual narratives.

g. Analyze, present, and publish the results of surveillance activities and epidemiologic investigations in consultation with CDC.

h. Focus and/or re-direct surveillance activities as indicated through critical

review of data and evaluation of yield from various surveillance activities.

i. In collaboration with CDC, initiate additional methods of surveillance for adult and/or pediatric HIV-related morbidity and mortality.

j. Participate in national planning and implementation meetings (e.g., National HIV/AIDS Surveillance Workshop) by ensuring that appropriate representatives attend using travel funds provided through this cooperative agreement.

k. Provide in the application the current reporting laws/regulations for the applicant's jurisdiction related to reporting of HIV infection, HIV disease, and AIDS. Provide copies of regulations protecting confidentiality of HIV/AIDS reports, including release of data, if not contained in the reporting laws.

2. Expanded Initiatives for HIV/AIDS Surveillance

Conduct alternative surveillance initiatives to define the spectrum of HIV-related disease, identify the contribution of HIV infection to mortality trends, characterize the behaviors and needs of HIV-infected persons with and without AIDS, and test alternative methods.

Specific required expanded initiative/evaluation activities: a. *Spectrum of Disease.*

Tasks:

Identify one or more hospitals (including the hospital ER and affiliated clinics) and/or one or more separate outpatient facilities (e.g., physicians' offices, public health clinics, health maintenance organizations) which treat a large volume of AIDS patients and other persons with HIV infection and disease.

For a prospective period, record all or a sample of patients who are admitted, evaluated, and/or treated because of illness associated with confirmed or suspected HIV infection. Sampling methods will be developed in collaboration with CDC to ensure sufficient representation of persons with different gender, race/ethnicity, and mode of HIV exposure.

Through review of medical records using data collection forms and software developed collaboratively by participating areas and CDC, describe all AIDS indicator diseases that have been diagnosed at any time in the past, and for the preceding 12-month period and subsequent 6-month intervals:

- illnesses that occur in identified HIV-infected persons
- use of antiviral and other medications for treatment of HIV disease and

- treatment or prevention of its complications
- results of CD4+ lymphocyte tests and other tests of immunologic function
- use of specific diagnostic or screening tests
- use of health services

Suggested Methods: Prospectively identify persons diagnosed with definitive or presumptive HIV infection and conduct surveillance for morbidity and mortality in selected hospitals, outpatient clinics, health maintenance organizations, and/or physician practices.

b. Use of the National Death Index (NDI) to Evaluate Mortality in AIDS Patients.

Tasks:

Abstract data from death certificates already on file.

Develop list of persons with AIDS presumed living with appropriate identifiers for NDI.

Submit list of cases directly to National Center for Health Statistics (NCHS). NCHS will provide from the NDI match, a list of possible matches—death certificate numbers, state of death certificate registration to state/local areas.

Request death certificates from and confirm matches to their case surveillance reports.

Add selected data from death certificates (e.g., cause of death, location of death) to states/cities surveillance records, using a special modification of the AIDS Reporting System.

Suggested methods: Many areas already collect death certificates as part of AIDS surveillance. These records would be abstracted. In addition, the NDI provides matches between individual names and death certificates. Data from selected cities and/or states would be provided directly to NCHS. Matches identified from the NDI would then be verified by obtaining death certificates from state health departments. Information from death certificates would be added to state/city surveillance records.

c. Supplement to HIV/AIDS Surveillance. Collect supplemental information on AIDS cases and reports of HIV infection in reporting areas that have a need to know.

Categories of information may include: (1) More detailed information on race/ethnicity and social and economic status.

(2) Illicit drug use (injecting and "crack").

(3) Changes in sex behaviors associated with HIV transmission and occurrence of other sexually transmissible diseases.

(4) Use of medical care (outpatient and inpatient services, treatments) and social services.

(5) Gynecologic and reproductive health.

(6) Risk behaviors among young adults, and

(7) Extent and types of disabilities.

Suggested Methods: Supplemental information would be collected through interviews with persons newly reported with HIV infections or AIDS as an extension of routine investigations of AIDS cases or HIV infections in participating states/cities. Standardized modules for each topic have been developed by CDC and participating areas, and CDC is providing computer software. These modules may be modified or extended in subsequent project years.

3. Serosurveillance Activities

a. Description of Surveys and Studies—(1) Ongoing Serosurveillance Activities. (a) Conduct ongoing unlinked serosurveys in childbearing women: monitor HIV in childbearing women nationwide using newborn filter paper blood specimens; and improve data completeness, quality, and reporting to CDC (e.g., to include age, race/ethnicity, county of birth). The protocol for this survey is the existing CDC protocol for seroprevalence surveys in childbearing women, May 1, 1992. Sample size recommendations may change from those previously used.

(b) Conduct ongoing unlinked serosurveys in patients at drug treatment centers (DTC) and at clinics for sexually transmitted diseases (STD), tuberculosis (TBC), homeless persons, women having induced abortions, and adolescents to determine prevalence and monitor trends of HIV infection in these sentinel groups.

(c) Continue HIV-2 surveillance by testing sera from ongoing surveys at STD clinics and DTC in a subset of sentinel cities. An applicant may request support for serosurveillance activities in some or all of these clinical settings.

(d) For the following surveys and studies, the specific clinics proposed must be able to meet the minimum sample size requirements in the corresponding protocols, unless otherwise noted.

STD Patients: In 20 cities, monitor HIV prevalence in STD patients in 1-2 principal clinics per city (up to 40 clinics nationally) that collect risk behavior information routinely from all clients. The protocol for this study is the existing CDC protocol for seroprevalence surveys in STD clinics, June 1, 1990.

Drug Users: In 20 cities, monitor HIV prevalence in drug users in (1) 1-3 principal drug treatment centers per city (30-40 centers nationally) that provide treatment to injecting drug users (not limited to heroin users), and (2) up to 3 centers per city (10-20 centers nationally) that provide treatment to users of drugs by routes other than injection (such as crack cocaine users). The protocol for this survey is the existing CDC protocol for seroprevalence surveys in drug treatment centers, June 1, 1990.

Homeless Persons: In 15-20 cities nationally (up to 2 clinics per city), monitor HIV prevalence in homeless persons. The protocol for this survey is the existing CDC protocol for seroprevalence surveys in clinics serving homeless persons, June 1, 1990.

Adolescents: In 20 cities, monitor HIV prevalence in up to 3 adolescent clinics per city (30-40 clinics nationally) that collect risk behavior information routinely from all clients; up to 3 juvenile detention centers per city (total of 20 centers nationally); and in 10 cities, monitor HIV prevalence in up to 3 clinics (total of 10 clinics nationally) serving homeless youth. The protocols for these surveys are the existing CDC protocols for seroprevalence surveys in clinics for homeless persons, clinics for adolescents and in juvenile detention centers, June 1, 1991.

TB Patients: In 10 cities, monitor HIV prevalence in all clinics which each routinely obtain blood samples from at least 100 confirmed and suspect TB cases per year. The protocol for this survey is the existing CDC protocol for seroprevalence surveys in TB clinics, June 1, 1990.

Women Having Induced Abortions: Monitor HIV prevalence in women seeking abortions at abortion clinics in 4-5 cities where demographic data from the survey in childbearing women and abortion clinics are comparably complete in terms of age, race, and area of residence. Evaluate whether women having induced abortions are more or less likely to be HIV infected than childbearing women in the same city. The protocol for abortion clinic surveys is the existing CDC protocol for seroprevalence surveys in clinics serving women of reproductive age, June 1, 1990.

(e) Evaluate trends in seroprevalence in each sentinel clinic. The minimum sample size for unlinked surveys should be increased based on observed clinic rates in previous years' unlinked surveys by extending the survey period to collect more specimens. The current minimum sample size for each survey is

given in the CDC protocols. Proposed increased sample sizes will be evaluated individually for each clinic.

(f) **Sentinel Hospital Patients: Monitor HIV seroprevalence among acute-care patients in 5 hospitals through unlinked serosurveys.** (There will be an additional 5 hospitals supported directly through contracts.) Patients will be sampled regardless of presenting clinical condition. HIV-positive specimens will be tested for beta-2-microglobulin. The protocol for this study is the existing CDC protocol for seroprevalence surveys in sentinel hospitals (universal sample), May 1989.

(2) **New Time-limited Surveys and Studies.** Any state or other governmental authority conducting surveys in childbearing women may be funded for evaluation of prenatal and perinatal HIV testing as described below. For the other new time-limited surveys and studies, only those metropolitan areas selected for clinic-based surveys will be funded.

(a) **New Surveys and Studies based on Interviews.**

Compare Injecting Drug Users in High and Low Prevalence Areas: Evaluate behavioral and other differences between injecting drug users attending drug treatment centers in 2 "high" (approximately 15% or above) HIV prevalence areas and 2 "low" (approximately 5% or below) prevalence areas from among the 20 sentinel cities through modification of the risk behavior (nonblinded) surveys used through 1992. Drug users will be retested one time within one year of interview to provide a comparison of seroincidence in low and high prevalence areas. Areas conducting unlinked surveys in drug treatment centers may apply for inclusion as either a "high" or a "low" prevalence area based on findings from previous unlinked surveys. A standardized protocol for this study will be developed in 1993 by a working group composed of persons from CDC and the funded areas.

Assess Risk Behaviors in Homeless Persons: Assess risk behaviors in homeless persons, including adolescents, in 5-10 clinics providing services specifically for the homeless from among the 15-20 clinics conducting unlinked surveys. The final standardized protocol for this study will be based on the existing CDC protocol for risk behavior surveys in homeless persons and will be developed early in 1993 by a working group composed of persons from CDC and the funded areas.

Assess Risk Behaviors in Adolescents: Within the cities conducting HIV serosurveys, assess HIV risks through cross-sectional interview-

based surveys in adolescents attending 6-10 clinics specifically serving youth and in adolescents seeking services at 6-10 general STD clinics. The standardized protocol for this study will be developed early in 1993 by a working group composed of persons from CDC and the funded areas.

Assess Risk Behaviors in Adolescent and Young Adult Men Who Have Sex with Men: Assess risk behaviors and prevalence of HIV and STD infections in young men, recruited from sites other than clinics, who have sex with men. Evaluate markers to stage HIV infection (e.g., beta-2-microglobulin, CD4 count) in this population for possible inclusion in ongoing studies. Five sites from among the 20 sentinel cities will be funded for one year with the possibility of a repeat study in selected areas. A draft protocol for this study has been developed and will be finalized early in 1993 by a working group of persons from CDC and the funded areas.

(b) **New Surveys and Studies Not Necessarily Involving Interviews.**

Evaluate Effects of Prenatal and Perinatal HIV Testing Policies: Evaluate effects of voluntary prenatal or perinatal HIV testing in 2-4 states that have adopted policies on HIV screening for women or infants. These studies will be funded in states that have ongoing surveys in childbearing women and that have existing or proposed mechanisms for providing counseling and testing of prenatal or childbearing women along with subsequent referral, follow-up, and treatment of seropositive women. Methods for this 12-month study will be chosen by the applicant.

Evaluate Stable or Decreasing Prevalence in STD Clinics: To document prospectively whether new infection is occurring in STD patients during a time when overall prevalence is stable or decreasing in the STD clinic, develop "passive" cohorts to assess patient seroconversion between repeat visits by linking STD records or by other methods to be proposed by the applicant. Three to five clinics with stable or decreasing seroprevalence documented in previous CDC unlinked surveys will be funded for this activity for 1-2 years, to be conducted concurrently with unlinked surveys.

Evaluate Coverage of Counseling and Testing in STD Clinics: In collaboration with STD Program Managers, prospectively evaluate the extent to which HIV-infected STD patients access HIV testing and receive test results in STD clinics. The results will be used to develop guidelines for clinics to evaluate their testing coverage of HIV-infected persons using serosurvey data. Four clinics concurrently conducting

unlinked serosurveys will be funded for this activity for 1 year.

Other Studies: Limited funds will be available for special studies related to HIV serosurveillance. These studies may include: innovative approaches for using serosurveillance data to target and evaluate prevention programs or to evaluate specific interventions; projections and trend analysis in selected populations using serosurveillance data; application of HIV staging markers (e.g., beta-2-microglobulin, CD4 count) in serosurveillance projects; and studies of other viruses and their association with HIV infection.

b. **Specific Required HIV Serosurveillance Activities**

(1) **Survey Protocols—(a) For Ongoing Unlinked Surveys.** For ongoing unlinked serosurveillance activities (Section 3.a(1)), applicants must comply with the latest CDC protocols for unlinked HIV seroprevalence surveys (STD, TB, WHC, DTC, homeless, juvenile detention centers, adolescents), dated June 1, 1990; Survey in Childbearing Women (SCBW), May 1, 1992; and future revisions. Applicants must use CDC data collection forms for all surveys and studies except the SCBW. Copies of protocols and forms are available from the Division of HIV/AIDS (DHA) program consultants.

(b) **For New Surveys and Studies.** Participants in a given type of study will form a working group to meet with the respective CDC Project Officer to finalize a mutually agreed upon standardized protocol and, where applicable, a study questionnaire. The protocol and questionnaire will be used by all areas, with potential for additions and variations of local interest, if approved in advance by CDC.

(2) **Develop and maintain a data base of demographic and risk behavior information and HIV test results to be provided line-by-line on a monthly basis to CDC.** These data bases must be kept securely and have procedures in place to ensure anonymity of test results.

(a) **Survey in Childbearing Women.** For the survey in childbearing women, data should be transferred to CDC within 3 months of birth and within 1 month of testing. Demographic variables should be completed on at least 95 percent of records.

(b) **Ongoing Clinic-based Surveys.** For serosurveillance activities based on clinics, data must be provided to CDC using HFS software within 1 month of collection.

(c) **New Time-limited Surveys and Studies.** For new surveys and studies, all data generated must be provided to

CDC monthly in the format agreed upon in the standardized protocol.

(3) Aliquot and store sera from clinic surveys and selected eluates from neonatal testing that remain after completion of HIV testing. Specimens will be held for one calendar year following the survey period to provide specimens for other studies and for quality control purposes. One 0.5-ml aliquot of each serum specimen is to be provided upon request to CDC. Dried blood spot eluates are to be selected and stored as described in the protocol for the SCBW and provided upon request to CDC.

(4) (a) **Survey in Childbearing Women.** Use serosurveillance data to develop, implement, and evaluate policies for counseling and voluntary HIV testing and provision of care for reproductive-age women or HIV screening of infants.

(b) **Clinic-based Surveys.** Assure that summary serosurveillance data are made available at least quarterly to participating clinic sites and to those responsible for prevention activities to assist in planning and evaluating prevention activities.

(5) Ensure that other studies proposed for the clinic settings do not hinder the timely completion of serosurveys and studies funded by this cooperative agreement.

(6) Participate in national planning and implementation meetings, (e.g., the National HIV Serosurveillance Workshop) by ensuring that appropriate representatives attend, using travel funds provided through this cooperative agreement for these meetings.

(7) Provide laboratory services, including screening tests, confirmatory procedures, and training of personnel necessary to support serosurveys and studies. Participate in a laboratory performance evaluation program for HIV testing. For consistency of HIV serologic survey data from state to state, applicants must use an FDA-licensed enzyme immunoassay kit (EIA) for all HIV-1 screening (this may be a combined HIV-1/HIV-2 EIA), and (except for the SCBW) an FDA-licensed HIV-1 Western blot kit for supplemental testing of repeatedly reactive serum specimens which are part of the HIV-1 serologic surveys and studies supported by these agreements. Since no Western blot kit has been licensed for use with dried blood spots, equipment and reagents approved by CDC for the Western blot assay must be used in the SCBW. Areas previously included in the CDC serosurveillance system for HIV-2 infection in STD clinics and drug treatment centers may use an FDA-licensed EIA for HIV-1/HIV-2 screening (combi kit) and, in addition to the HIV-1

Western blot kit described above, an FDA-licensed supplemental or confirmatory test(s) for HIV-2 in accordance with the manufacturer's recommendations. The algorithms for HIV testing recommended by CDC and the Association of State and Territorial Public Health Laboratory Directors (ASTPHLD) must be followed.

4. Optional Recipient Activities

To increase flexibility of this cooperative agreement, recipients may, with prior CDC approval, redirect during 1993 up to 5% of their total award for emerging surveillance/serosurveillance needs. This funding is intended to support focused, one-time projects (e.g., serosurvey in a prison hospital, evaluation of surveillance completeness, etc.) and to obtain information specifically required for policy decisions or planning prevention programs at the state or local level. Any study involving HIV testing must use an Institutional Review Board (IRB)-approved CDC protocol or guidelines. Proposals for these projects should not be described in this application, but should be submitted during the budget year as funds are identified to support them.

B. Centers for Disease Control Activities

1. Provide consultation and scientific and technical assistance in planning, operating, analyzing, and evaluating serosurveillance, surveillance, and expanded initiatives activities.

2. Provide training in surveillance methodology, serosurveillance survey and study methodology, and in program planning and management.

3. Provide (1) a national performance evaluation system for laboratory procedures related to the EIA, Western blot, and CD4 lymphocyte analysis, or other appropriate testing procedures, and (2) laboratory training that includes current scientific and technical information about the practical and the theoretical sensitivity and specificity of the different serological tests.

4. Develop, refine, and disseminate HIV/AIDS surveillance program information which describes effective methods to carry out program activities and monitor progress.

5. Provide criteria for the surveillance definition of nationally reported HIV infection/disease, case report forms, and assistance in establishing and maintaining the computerized AIDS Reporting System (ARS), HIV Reporting System (HRS) and HIV Family of Surveys (HFS).

6. Participate in the analysis of information and data gathered from program activities and facilitate the

transfer of information and technology among all states and communities.

7. Provide standardized protocols for ongoing serosurveillance activities, data collection forms, and computer software for the CDC serosurveillance surveys. Participate in working groups with funded areas to finalize mutually agreed upon standardized study protocols and, where appropriate, data collection instruments for the new time-limited surveys and studies.

8. Assist in the evaluation of the overall effectiveness of program operations, including the impact of serosurveillance data on the development of public policy and on targeting and evaluating prevention activities.

9. Provide standard data collection forms, questionnaires, and computer software for the Expanded Initiatives activities.

Evaluation Criteria

Each application will be reviewed and evaluated individually according to the following criteria.

A. HIV/AIDS Surveillance (100 Points)

1. The extent to which HIV/AIDS surveillance activities have been or will be strengthened in inpatient and outpatient facilities and laboratories by addressing the following issues:

- (1) Educating providers about reporting;
- (2) establishing criteria for active surveillance sites;
- (3) enrolling or removing sites from the active surveillance net;
- (4) frequency and content of surveillance visits;
- (5) establishing liaison with laboratories doing CD4 lymphocyte analysis, EIA, and Western blot testing;
- (6) identifying and accessing a population-based secondary data set (e.g., death certificates);
- (7) analyzing and disseminating data;
- (8) evaluating yield from various surveillance activities; and
- (9) following-up on cases of epidemiologic interest, (e.g., NIR's, particularly among health-care workers, transfusion cases after March 1985). (50 points)

2. The extent to which AIDS and HIV infection surveillance data are submitted to CDC in a complete manner on at least a monthly basis. (5 points)

3. The extent to which HIV/AIDS surveillance activities have or will assist in prevention activities, in formulating and targeting additional prevention strategies, the continued development of linkages to available medical and social

support services, and to the projection of trends. (10 points)

4. The extent to which the project objectives are realistic, specific, measurable, and address the required recipient activities. (10 points)

5. The extent to which realistic plans for evaluation of project activities have been developed and implemented and the quality of such plans. (10 points)

6. The extent to which the applicant has in place adequate procedures to ensure the physical security of HIV/AIDS reports and policies or legislation to protect the confidentiality of persons reported with HIV/AIDS. (15 points)

7. The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

B. Expanded Initiatives

Competing continuation Applications: (Applications for ASD, NDI, and SHAS will be evaluated separately based on 100 points each.) Competing continuation awards will be made on the basis of the following criteria:

1. Satisfactory documentation of progress in meeting project objectives for each component, including the extent to which: potential sources of surveillance data have been identified, accessed, and used; procedures for protection of confidentiality have been adequately described; proper conduct of the study component has been documented, including ability to provide CDC with computer diskettes containing standard data items from software program; data from the project have been used locally; the project has been used to augment and enhance ongoing HIV or AIDS surveillance (i.e., AIDS reporting, updating HIV exposure information; updating vital status). (40 points)

2. The extent to which the objectives for each component for the new budget period are realistic, specific, and address the required recipient activities. (30 points)

3. The potential success of the new or revised methods of operations in meeting the proposed objectives. (20 points)

4. The appropriateness of any proposed changes in evaluation plans. (10 points)

5. The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

New Competing Applications: (Applications for ASD and SHAS will be evaluated separately based on 100 points each.) Applications for new competing awards will be reviewed and evaluated based on the evidence

submitted which specifically describes the applicants' abilities to meet the following criteria:

1. The quality of plans to develop and implement the initiative project describing how potential sources of surveillance data will be identified, accessed, and used, including a plan to protect the confidentiality of all surveillance data. In addition, plans to integrate the project with ongoing HIV/AIDS surveillance should be described, including assurances that data collected from the project (i.e., AIDS reporting, updating HIV exposure information, updating vital status) will be used to augment and enhance the surveillance database. Specifically:

ASD

The ASD project will be evaluated on the quality of plans to include procedures to identify patients from outpatient facilities and inpatient facilities (or to obtain information on hospitalizations), and emergency rooms. In addition, procedures to obtain information on gynecologic and oncologic diagnoses should be described if these services are not provided in the clinics or other settings that are the primary focus of surveillance activities.

SHAS

The SHAS project will be evaluated on the ability to identify and interview persons with AIDS or HIV infections without AIDS. For those states interviewing persons with HIV infections, priority should be given to those with newly recognized infection and those with a known interval of HIV seroconversion, (e.g., those with previously documented negative tests). (25 points)

2. ASD

The ability to follow an adequate number of HIV-infected persons, including men and women of different racial/ethnic groups and with different modes of HIV exposure, to assure proper conduct of the study. The known or projected prevalence of HIV infection in the population to be studied and characterization by racial/ethnic group, gender, and mode of HIV exposure will be an important area of consideration.

SHAS

New applicants to the SHAS project will be evaluated on their ability to improve the representation of individuals from specific geographic areas, ethnic groups, and/or persons with newly recognized HIV infection. Regarding ethnicity, sites should document their capacity for including substantial numbers of Hispanic

individuals of Puerto Rican ancestry. Regarding inclusion of persons with newly recognized HIV infection, sites should document their capacity for determining whether information is available on previous negative tests among such individuals. (25 points)

3. The applicant's understanding of the objectives of the surveillance initiative or evaluation and the applicant's ability, willingness and/or need to cooperate in a study with CDC and other participants, including use of standard protocols and software developed by CDC and participating sites during the initial project year in 1989. (15 points)

4. The applicant's current and/or past activities in the surveillance of AIDS, other HIV disease, and asymptomatic HIV infection and how they will be applied to achieving the objectives of the evaluation study or expanded initiative. (15 points)

5. How the project will be administered, including the size, qualifications, and time allocation of the proposed staff and the availability of facilities to be used during the surveillance evaluation/initiative and a schedule for accomplishing the activities of the evaluation/initiatives, including time frames. (20 points)

6. The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

C. HIV Serosurveillance

1. Survey in Childbearing Women

For Competing Continuation Applications (100 points). The extent to which the applicant:

a. Demonstrates that survey data will complement data otherwise available from AIDS surveillance and HIV infection reporting. (10 points)

b. Documents ways that survey data have been used to help formulate public health policies and direct prevention activities. (10 points)

c. Has previously conducted the survey in accordance with the CDC survey protocol. (20 points)

d. Specifies laboratory methods conforming to CDC protocol (specimen collection and storage, HIV testing procedures, participation in quality assurance program). (20 points)

e. Describes and documents collaboration among epidemiology, HIV laboratory, metabolic screening and AIDS program components of the health department. (10 points)

f. Has previously collected adequate specimens and data with satisfactory demographic detail; describes plans for

improving specimen and data quality. (20 points)

g. Details acceptable data management procedures, including linkage of laboratory and demographic data, editing and correction of errors, and transmission to CDC. (5 points)

h. Delineates administration of the project, including size, qualifications, time allocation and supervision of proposed staff. (5 points)

i. Provides a budget that is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

For New Applications (100 points).

The extent to which the applicant:

a. Demonstrates that survey data will complement data otherwise available from AIDS surveillance and HIV infection reporting. (10 points)

b. Documents ways that survey data will be used to help formulate public health policies and direct prevention activities. (10 points)

c. Demonstrates understanding, ability, and willingness to follow the CDC survey protocol. (20 points)

d. Specifies laboratory methods conforming to CDC protocol (specimen collection and storage, HIV testing procedures, participation in quality assurance program). (20 points)

e. Describes and documents collaboration among epidemiology, HIV laboratory, metabolic screening and AIDS program components of the health department. (10 points)

f. Demonstrates an ability to collect adequate specimens and data with satisfactory demographic detail. (20 points)

g. Details acceptable data management procedures, including linkage of laboratory and demographic data, editing and correction of errors, and transmission to CDC. (5 points)

h. Delineates administration of the project, including size, qualifications, time allocation and supervision of proposed staff. (5 points)

i. Provides a budget that is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

2. Ongoing Unlinked Surveys and New Time-limited Surveys (100 Points)

a. The extent to which previously funded surveys and studies have been implemented and conducted in accordance with CDC protocols. (30 points)

b. The ability in previously funded serosurveillance activities to achieve required sample sizes in unlinked surveys, to enroll the required number of participants in Surveys of Risk Behaviors, to collect essential data and

to ensure good data quality according to CDC protocols. (25 points)

c. The extent to which data from previously funded serosurveys were submitted to CDC in a timely (i.e., monthly) and complete manner using HFS software. (10 points)

d. The extent to which valid data from previously funded surveys are available to follow trends over several years. (15 points)

e. The diversity of survey and special project opportunities offered by the applicant. (10 points)

f. The applicant's ability and willingness (documented in part by letters from proposed clinics or hospitals indicating concurrence with the study plans) to cooperate in new studies with CDC and other participants, including the use of standardized protocols and software developed by CDC and the participating health departments during the next project year. (10 points)

g. The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds. (Not scored)

Funding Priorities

A. HIV/AIDS Surveillance

1. Surveillance of AIDS (AIDS)

2. Adult/Adolescent HIV Infection Surveillance (AAHIS)

3. Pediatric HIV Infection Surveillance (PHIS)

Highest priority will be given to continuing support for applicants currently receiving support for these projects.

B. Expanded Initiatives for HIV/AIDS Surveillance

Highest priority will be given to continuing support for applicants currently receiving support for these projects.

1. Adult Spectrum of Disease

Priority for new competing applications for the Adult Spectrum of Disease Project will be given to those applicants who document an ability to implement alternative (to routine AIDS case reporting) surveillance techniques and to identify and follow a substantial number of (1) HIV-infected women, and who can enlist the participation of those facilities that provide obstetrical/gynecological services to HIV-infected women, (2) HIV-infected persons of minority racial/ethnic groups, and (3) HIV-infected persons who are injecting drug users and those who were exposed to HIV through heterosexual contact.

2. Supplement to HIV/AIDS Surveillance

Priority for new competing applications for the Supplement to HIV/AIDS Surveillance project will be given to those geographic areas who document their ability to (1) improve the representation of Hispanic individuals of Puerto Rican ancestry and/or (2) those areas who can improve the representation of persons with newly recognized HIV infections, especially persons with a known interval between the last seronegative HIV result and seroconversion, (e.g., ability to obtain information on previous test results during post-test counseling).

3. National Death Index

Funds are not available for new competing awards for National Death Index projects to evaluate mortality of AIDS patients (NDI).

C. HIV Serosurveillance

1. Survey in Childbearing Women

Highest priority will be given to those states (as well as the District of Columbia and Puerto Rico) currently receiving support for these projects.

2. Ongoing Unlinked Surveys and new Time-limited Surveys and Studies (based primarily in clinics)

Twenty "sentinel cities" will be funded for clinic-based surveys. Selection of sentinel cities will be competitive and based on demonstrated good past performance on serosurveys to permit continued monitoring of trends and on the opportunity in the project area to conduct the various types of surveys and studies.

Priority will be given to selecting sentinel cities which will, as a group, provide both geographic and epidemiologic diversity to facilitate monitoring the various patterns of HIV in the country. Approximately 40% of the selected cities will be located in the states and territories along the Atlantic coast (including Puerto Rico), 25% in the Rocky Mountain and Pacific states, and 35% in the remainder of the country. While the majority of funds will be awarded to major metropolitan areas, some smaller population centers will be included. Of the funded areas, approximately 40% will have low seroprevalence (at or below the national median) in females without acknowledged risk attending STD clinics and in injecting drug users entering drug treatment as demonstrated by previous CDC-funded unlinked surveys. For national median values, refer to the *National HIV*

Serosurveillance, Summary of Results through 1990. Approximately 60% will have higher seroprevalence rates (above the national median) in these target groups. Priority will also be given to areas with opportunities to conduct studies in adolescents and in clinics specifically serving men who have sex with men.

Executive Order 12372

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order 12372. E.O. 12372 sets up a system for state and local government review of proposed Federal assistance applications. Applicants (other than federally recognized Indian tribal governments.) should contact their state Single Point of Contacts (SPOCs) as early as possible to alert them to the prospective applications and receive any necessary instructions on the state process. For proposed projects serving more than one state, the applicant is advised to contact the SPOC for each affected state. A current list of SPOCs is included in the application kit. If SPOCs have any state process recommendations on applications submitted to CDC, they should forward them to Edwin L. Dixon, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road, NE., room 300, Atlanta, GA 30305, no later than 60 days after the application deadline. The granting agency does not guarantee to "accommodate or explain" state process recommendations it receives after that date.

Catalog of Federal Domestic Assistance Number

The Catalog of Federal Domestic Assistance Number is 93.118.

Other Requirements

Paperwork Reduction Act

Projects initiated under B.1., B.3. (Expanded Initiatives for HIV/AIDS Surveillance), C.1.-C.3. (HIV Serosurveillance) that involve the collection of information from 10 or more individuals and funded by cooperative agreement will be subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act. Data collection initiated under sections A.1.-A.3. (HIV/AIDS Surveillance) has been approved by the Office of Management and Budget under number 0920-0004, "National Disease Surveillance Program I. Case Report," Expiration date 11/92. Data collection initiated under section B.2. (Expanded

Initiatives for HIV/AIDS Surveillance) has been approved under number 0920-0282, "Supplement to AIDS Case Reporting," Expiration date 7/93.

Human Subjects

If the proposed project involves research on human subjects, the applicant must comply with the Department of Health and Human Services Regulations (45 Code of Federal Regulations part 46) regarding the protection of human subjects. Assurance must be provided to demonstrate that the project will be subject to initial and continuing review by an appropriate institutional review committee. The applicant will be responsible for providing assurance in accordance with the appropriate guidelines and form provided in the application kit.

HIV/AIDS Requirements

Recipients must comply with the document entitled "Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions," (June 1992), a copy of which is included in the application kit. In complying with the requirements for a program review panel, recipients are encouraged to use an existing program review panel such as the one created by the state health department's HIV/AIDS prevention program. If the recipient forms its own program review panel, at least one member must be an employee (or a designated representative) of a governmental health department consistent with the Content guidelines. The names of the review panel members must be listed on the Assurance of Compliance Form CDC 0.113, which is also included in the application kit. The recipient must submit the program review panel's report that indicates all materials have been reviewed and approved.

Application Submission and Deadline

The original and two copies of the application, PHS Form 5161-1, must be submitted to Edwin L. Dixon, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road, NE., room 300, Mailstop E-14, Atlanta, GA 30305, on or before September 30, 1992.

1. *Deadline:* Applications shall be considered as meeting the deadline if they are either:

- Received on or before the deadline date; or
- Sent on or before the deadline date and received in time for submission to the independent review group.

(Applicants should request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable proof of timely mailing.)

2. *Late Applications:* Applications which do not meet the criteria in 1.a. or 1.b. above are considered late applications. Late applications shall not be considered in the current competition for funding and will be returned to the applicant.

Where to Obtain Additional Information

A complete program description, information on application procedures, an application package, and business management technical assistance may be obtained from Nealean K. Austin, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road, NE., room 300, Atlanta, GA 30305, Mailstop E-14, (404) 842-6508.

Programmatic technical assistance may be obtained from Willis R. Forrester, Field Services Branch, Division of HIV/AIDS, National Center for Infectious Diseases, Centers for Disease Control, Atlanta, GA 30333, (404) 639-2056.

Please refer to Announcement Number 302 when requesting information and submitting an application.

Potential applicants may obtain a copy of Healthy People 2000 (Full Report, Stock No. 017-001-00474-0) or Healthy People 2000 (Summary Report, Stock No. 017-001-00473-1), referenced in the Introduction, through the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325, (Telephone 202-783-3238).

Dated: August 25, 1992.

Robert L. Foster,

Acting Associate Director for Management and Operations, Centers for Disease Control.

[FR Doc. 92-20980 Filed 8-31-92; 8:45 am]

BILLING CODE 4160-18-M

National Minority Organization Consultant Meeting

The National Center for Prevention Services (NCPS) of the Centers for Disease Control (CDC) announces the following meeting:

Name: National Minority Organization (NMO) Consultant Meeting.

Time and Date: 8:30 a.m.-4:30 p.m., September 15, 1992.

Place: Hotel Nikko Atlanta, 3300 Peachtree Road, NE., Atlanta, Georgia 30305.

Status: Open to the public, limited only by space available.

Purpose: Representatives from CDC, other federal agencies, state and local health departments, community-based organizations and other consultants representing a broad cross section of racial/ethnic minority populations and geographic areas will review and discuss the draft program announcement for fiscal year 1993 funding of NMOs for human immunodeficiency virus (HIV) prevention.

Matters to be Discussed: Meeting attendees will review and comment on the draft program announcement. All suggestions will be considered when the final announcement is developed.

Contact Person for More Information: P. Imani Thompson, M.C.P., Ed.M., Health Education Specialist, NCPS (HIV), CDC, Mailstop E07, 1600 Clifton Road, NE., Atlanta, Georgia 30333, telephone 404/639-1480.

Dated: August 26, 1992.

Elvin Hilyer,

Associate Director for Policy Coordination
Centers for Disease Control.

[FR Doc. 92-20979 Filed 8-31-92; 8:45 am]

BILLING CODE 4160-18-M

Health Care Financing Administration

[OPA-004-N]

Medicare Program; Meeting of the Practicing Physicians Advisory Council

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Practicing Physicians Advisory Council. This meeting is open to the public.

DATES: The meeting is scheduled for September 14, 1992 from 9 a.m. until 5 p.m. e.d.t. An additional meeting is tentatively scheduled for December 14, 1992 from 9 a.m. until 5 p.m. e.s.t.

ADDRESSES: The meeting will be held in room 800, 8th Floor of the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: Matthew Crow, Executive Director, Practicing Physicians Advisory Council, room 425-H, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, (202) 690-7874.

SUPPLEMENTARY INFORMATION: The Secretary of the Department of Health and Human Services is mandated by section 1868 of the Social Security Act, as added by section 4112 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990), to appoint a Practicing Physicians Advisory Council (the Council) based on nominations submitted by medical organizations representing physicians. The Council meets quarterly to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, the consultation must occur before publication of the proposed changes. The Council submits an annual report on its recommendations to the Secretary and the Administrator of the Health Care Financing Administration (HCFA) not later than December 31st of each year.

The Council consists of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under Medicare in the previous year. Members of the Advisory Council include both participating and nonparticipating physicians, and physicians practicing in rural and underserved urban areas. At least 11 members must be doctors of medicine or osteopathy authorized to practice medicine and surgery by the States in which they practice. Members have been invited to serve for overlapping 4-year terms. In accordance with section 14 of the Federal Advisory Committee Act, terms of more than 2 years are contingent upon the renewal of the Advisory Committee by appropriate action before the end of the 2-year term.

The current members are: Gary Dennis, M.D., Harvey Hanlen, D.O., Kenneth Hansen, M.D., Isabel Hoverman, M.D., Ramon Jimenez, M.D., Jerilyn Kaibel, D.O., William Kirsch, D.O., Marie Kuffner, M.D., David Massanari, M.D., Kenton Moss, M.D., Susan Owens, M.D., Isadore Rosenfeld, M.D., Richard Tompkins, M.D., James Waites, M.D., and Gary Yordy, M.D. The chairperson is Richard Tompkins, M.D.

The Council will discuss items in connection with staff leasing by physicians. Section 1861(s)(2)(A) of the Social Security Act provides for the coverage of services and supplies furnished incident to a physician's professional service. The implementing manual instructions set forth in section 2050 of the Medicare Carriers Manual stipulate that services furnished by a physician's auxiliary personnel can be covered under this benefit only if the

auxiliary personnel are employees of the physician. In addition, the Council will discuss HCFA's "Dear Doctor" letter, which is sent to all physicians given them the opportunity to enroll as a participating physician in the Medicare program.

Those individuals or organizations who wish to make 10-minute oral presentations on scheduled topics must contact the Executive Director to be scheduled. For the name, address and telephone number of the Executive Director, see the "FOR FURTHER INFORMATION CONTACT" section at the beginning of this notice. A written copy of the oral remarks must be presented to the Executive Director at the time of the presentation. Anyone who is not scheduled to speak may submit written comments to the Executive Director. The meeting is open to the public but attendance is limited to the space available on a first-come basis.

Authority: Section 1868 of the Social Security Act (42 U.S.C. 1395ee) and section 10(a) of Pub. L. 92-463 (5 U.S.C. App. 2, section 10(a)).
(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 19, 1992.

William Toby,

Acting Deputy Administrator, Health Care Financing Administration.

[FR Doc. 92-21024 Filed 8-31-92; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Geological Survey

Mineralogical Infrared Data Set From MACH I Inc.

AGENCY: U.S. Geological Survey.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. Geological Survey has accepted from MACH I Inc. a Mineralogical Infrared Data Set, containing mineral and infrared spectra data, and the use of a Perkin Elmer IR Data Station Model 3600 and Model 660 Graphic Printer to work with the data. This reference library of mineral spectra can be used to assist in mineral identification and characterization.

DATES: This notice is effective September 1, 1992.

ADDRESSES: Material in the data set is available to the public upon request at the following location: U.S. Geological Survey, Branch of Central Mineral

Resources, Denver Federal Center, Bldg. 25, Lakewood, Colorado 80225.

FOR FURTHER INFORMATION CONTACT:

Dr. Eugene Foord of the U.S. Geological Survey, Branch of Central Mineral Resources, at the address given above; telephone 303/236-4755.

B.A. Morgan,

Chief Geologist.

[FR Doc. 92-20808 Filed 8-31-92; 8:45 am]

BILLING CODE 4310-31-M

National Park Service

**Concession Contract Negotiations;
Jefferson National Expansion
Historical Association**

AGENCY: National Park Service, Interior.

ACTION: Public notice.

SUMMARY: Public notice is hereby given that the National Park Service proposes to negotiate a concession permit with the Jefferson National Expansion Historical Association authorizing it to continue to provide photographic film/supplies and female sanitary napkins facilities and services for the public at the Jefferson National Expansion Memorial National Historic Site, Missouri, for a period of five (5) years from September 1, 1990, through August 31, 1995.

EFFECTIVE DATE: November 2, 1992.

ADDRESS: Interested parties should contact the Superintendent, Jefferson National Expansion Memorial National Historic Site, 11 North Fourth Street, St. Louis, MO 63102, for information as to the requirements of the proposed permit.

SUPPLEMENTARY INFORMATION: This permit renewal has been determined to be categorically excluded from the procedural provisions of the National Environmental Policy Act and no environmental document will be prepared.

The foregoing concessioner has performed its obligations to the satisfaction of the Secretary under an existing permit which expired by limitation of time on August 31, 1990, and therefore pursuant to the provisions of section 5 of the Act of October 9, 1965 (79 Stat. 969; 16 U.S.C. 20), is entitled to be given preference in the renewal of the permit and in the negotiation of a new proposed permit as defined in 36 CFR 51.5.

The Secretary will consider and evaluate all proposals received as a result of this notice. Any proposal, including that of the existing concessioner, must be postmarked or hand delivered on or before the sixtieth

(60th) day following publication of this notice to be considered and evaluated.

Dated: August 25, 1992.

Don H. Castleberry,

Regional Director, Midwest Region.

[FR Doc. 92-21036 Filed 8-31-92; 8:45 am]

BILLING CODE 4310-70-M

**National Register of Historic Places;
Notification of Pending Nominations**

Nominations for the following properties being considered for listing in the National Register were received by the National Park Service before August 22, 1992. Pursuant to § 60.13 of 36 CFR part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded to the National Register, National Park Service, P.O. Box 37127, Washington, DC 20013-7127. Written comments should be submitted by September 16, 1992.

Antoinette J. Lee,

Acting Chief of Registration, National Register.

California

Riverside County

First Church of Christ, Scientist, 3606 Lemon St., Riverside, 92001250.

Colorado

Denver County

Gebhard Mansion, 2253 Downing St., Denver, 92001254.

Connecticut

Fairfield County

Redding Center Historic District, Roughly, 4-25B Cross Hwy., including Read Cemetery, 61-100 Hill Rd., 0-15 Lonetown Rd. and 118 Sanfordtown Rd., Redding, 92001253.

Louisiana

Rapides Parish

Lecompte High School, 1610 Charter St., Lecompte, 92001251.

St. Tammany Parish

Dendinger House, 206 Covington St., Madisonville, 92001252.

Nevada

Churchill County

Churchill County Courthouse, 10 Williams St., Fallon, 92001258.

Elko County

Elko County Courthouse, 571 Idaho St., Elko, 92001259.

Washoe County

California Building, 1000 Cowan Dr., Idlewild Park, Reno, 92001257.

North Carolina

Lenoir County

Tull-Worth-Holland Farm, NC 1579 N side, .5 mi. E of jct. with NC 1578, Kinston Vicinity, 92001260.

Ohio

Ottawa County

Main Street Historic District, Roughly bounded by Eighth, Washington, Fifth and West Sts., Genoa, 92001261.

Oregon

Lane County

Patterson-Stratton House (Eugene West University Neighborhood MPS), 1605 Pearl St., Eugene, 92001262.

Tennessee

Shelby County

Pope, Leroy, Elementary School, 190 Chelsea Ave., Memphis, 92001263.

Washington County

Salem Presbyterian Church, 147 Washington College Rd., Washington College, 92001255.

Texas

Anderson County

Anderson County Courthouse, 1 Public Sq., Palestine, 92001256.

[FR Doc. 92-20936 Filed 8-31-92; 8:45 am]

BILLING CODE 4310-70-M

**INTERSTATE COMMERCE
COMMISSION**

[Ex Parte No. 509]

**Railroad Revenue Adequacy—1991
Determination**

AGENCY: Interstate Commerce Commission.

ACTION: Denial of motion for reconsideration in 1991 revenue adequacy determination.

SUMMARY: On July 22, 1992, the Commission served a decision in this proceeding (57 FR 32563). On July 24, 1992, the Association of American Railroads filed a Motion for Reconsideration requesting that the Commission use predecessor cost in lieu of acquisition cost in measuring the net investment base of the railroads. AAR also requests that the Commission confirm that, should AAR prevail in a court challenge it will modify the 1991

decision by using predecessor costs. We deny the motion to use predecessor cost in the instant decision, but do acknowledge that should AAR prevail in its court challenge, the 1991 decision would be modified accordingly.

EFFECTIVE DATE: This decision shall be effective on September 1, 1992.

FOR FURTHER INFORMATION CONTACT: Ward L. Ginn, Jr. (202) 927-5740 (TDD for the hearing impaired: (202) 927-5721).

SUPPLEMENTARY INFORMATION: By decision served July 22, 1992, published at 8 I.C.C.2d 666 (1992), the Commission issued its revenue adequacy findings for the nation's Class I railroads for the year 1991. In that decision, for the fourth time, we used acquisition cost in lieu of predecessor cost for determining the railroads' net investment bases. On July 24, 1992, the Association of American Railroads ("AAR") filed a motion for reconsideration arguing for the use of predecessor costs. AAR requests that, at the very least, the Commission confirm that if the court requires the use of predecessor costs, we will modify the 1991 revenue adequacy decision accordingly. Upon consideration of the AAR's petition, we conclude that our decision to use acquisition cost is correct. However, we acknowledge that AAR has preserved its acquisition cost argument by specifically raising it in the instant proceeding, and we agree that should the AAR prevail in its pending court appeal, it will be appropriate to recompute 1991 revenue adequacy for those railroads that would be affected by this issue.

Additional information is contained in a concurrent decision. To obtain a copy of the full decision, write to, call, or pick up in person from: Dynamic Concepts, Inc., Interstate Commerce Commission Building, room 2229, Washington, DC 20423.

TELEPHONE: (202) 289-4357/4359. [Assistance for the hearing impaired is available through TDD services (202) 927-5721.]

This action will not significantly affect either the quality of the human environment or energy conservation.

Decided: August 25, 1992.

By the Commission, Chairman Philbin, Vice Chairman McDonald, Commissioner Simmons, Phillip, and Emmett.

Anne K. Quinlan,
Acting Secretary.

[FR Doc. 92-20986 Filed 8-31-92; 8:45 am]

BILLING CODE 7035-01-M

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

[Prohibited Transaction Exemption 92-68; Exemption Application No. D-9042, et al.]

Grant of Individual Exemptions;
Ralston Purina Co., Savings
Investment Plan, et al.

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Grant of individual exemptions.

SUMMARY: This document contains exemptions issued by the Department of Labor (the Department) from certain of the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1986 (the Code).

Notices were published in the *Federal Register* of the pendency before the Department of proposals to grant such exemptions. The notices set forth a summary of facts and representations contained in each application for exemption and referred interested persons to the respective applications for a complete statement of the facts and representations. The applications have been available for public inspection at the Department in Washington, DC. The notices also invited interested persons to submit comments on the requested exemptions to the Department. In addition the notices stated that any interested person might submit a written request that a public hearing be held (where appropriate). The applicants have represented that they have complied with the requirements of the notification to interested persons. No public comments and no requests for hearing, unless otherwise stated, were received by the Department.

The notices of proposed exemption were issued and the exemptions are being granted solely by the Department because, effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type proposed to the Secretary of Labor.

Statutory Findings

In accordance with section 408(a) of the Act and/or section 4975(c)(2) of the Code and the procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990) and based upon the entire record, the Department makes the following findings:

(a) The exemptions are administratively feasible;

(b) They are in the interests of the plans and their participants and beneficiaries; and

(c) They are protective of the rights of the participants and beneficiaries of the plans.

Ralston Purina Company Savings Investment Plan (the Plan), Located in St. Louis, Missouri

[Prohibited Transaction Exemption 92-68; Exemption Application No. D-9042]

Exemption

The restrictions of sections 406(a), 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1)(A) through (E) of the Code, shall not apply to the advance of funds (the Advances) to the Plan by the Ralston Purina Company (Ralston), a party in interest with respect to the Plan, and a return of such funds with interest to Ralston upon the Plan's receipt of payments under two guaranteed investment contracts (the GICs) issued by Executive Life Insurance Company (ELIC), provided the following conditions are satisfied: (a) All of the terms of the transaction are no less favorable to the Plan than those which the Plan could obtain in an arms-length transaction with an unrelated party; (b) the Advances and interest thereon will be repaid only out of amounts paid to the Plan by ELIC, its successors, or any other responsible third party; (c) interest will be credited at the GIC Market Rate (as defined in the notice of proposed exemption) to each GIC after its stated maturity date; (d) Ralston will make the Advances at the Loan Rate (as defined in the notice of proposed exemption) from the date the Advances are made through the date they are repaid; (e) the Plan's liability to Ralston resulting from the transaction will in no event exceed the amounts paid to the Plan by or on behalf of ELIC, its successors or any other third party with respect to ELIC's obligations under the GICs; and (f) repayment of the Advances will be waived to the extent the Plan receives less from the disposition of the GICs than the total amount of the Advances, plus interest at the Loan Rate.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption, refer to the notice of proposed exemption published on July 7, 1992 at 57 FR 29894.

EFFECTIVE DATE: This exemption is effective June 30, 1992.

FOR FURTHER INFORMATION CONTACT:

Gary H. Lefkowitz of the Department, telephone (202) 523-8881. (This is not a toll-free number.)

The General Motors Hourly-Rate Employees' Pension Plan; The General Motors Retirement Program for Salaried Employees; The AT&T Pension Plan; and The AT&T Management Pension Plan together, the Plans, Located in Detroit, Michigan (the GM Plans) and in New York, New York (the AT&T Plans)

[Prohibited Transaction Exemption 92-69; Exemption Application Nos. D-9027 through D-9030]

Exemption

The restrictions of section 406(a) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1)(A) through (D) of the Code, shall not apply to (1) the proposed granting to The Industrial Bank of Japan, Limited, New York Branch (IBJ), as the representative of lenders (the Lenders) participating in a credit facility (the Facility), of security interests in limited partnership interests in The Morgan Stanley Real Estate Fund, L.P. (the Partnership) owned by the Plans with respect to which some of the Lenders are parties in interest; and (2) the proposed agreements by the Plans to honor capital calls made by IBJ in lieu of the Partnership's general partner; provided that (a) the proposed grants and agreements are on terms no less favorable to the Plans than those which the Plans could obtain in arm's-length transactions with unrelated parties; and (b) the decisions on behalf of each Plan in the Partnership and to execute such grants and agreements in favor of IBJ are made by a fiduciary which is not included among, and is independent of, the Lenders and IBJ.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption, refer to the notice of proposed exemption published on July 7, 1992 at 57 FR 29899.

FOR FURTHER INFORMATION CONTACT:

Gary H. Lefkowitz of the Department, telephone (202) 523-8881. (This is not a toll-free number.)

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest or disqualified person from certain other provisions to which the exemptions does

not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(B) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) These exemptions are supplemental to and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transactional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction; and

(3) The availability of these exemptions is subject to the express condition that the material facts and representations contained in each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, DC, this 27th day of August, 1992.

Ivan Strasfeld,

*Director of Exemption Determinations,
Pension and Welfare Benefits Administration,
U.S. Department of Labor.*

[FR Doc. 92-20990 Filed 8-31-92; 8:45 am]

BILLING CODE 4510-29-M

[Application No. D-9122, et al.]

Proposed Exemptions; Thomas S. Monaghan, Inc., et al.

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Notice of proposed exemptions.

SUMMARY: This document contains notices of pendency before the Department of Labor (the Department) of proposed exemptions from certain of the prohibited transaction restriction of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1986 (the Code).

WRITTEN COMMENTS AND HEARING REQUESTS:

All interested persons are invited to submit written comments or request for a hearing on the pending exemptions, unless otherwise stated in the Notice of Proposed Exemption, within 45 days from the date of publication of this **Federal Register** Notice. Comments and request for a

hearing should state: (1) The name, address, and telephone number of the person making the comment or request, and (2) the nature of the person's interest in the exemption and the manner in which the person would be adversely affected by the exemption. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing.

ADDRESS: All written comments and request for a hearing (at least three copies) should be sent to the Pension and Welfare Benefits Administration, Office of Exemption Determinations, room N-5649, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Attention: Application No. stated in each Notice of Proposed Exemption. The applications for exemption and the comments received will be available for public inspection in the Public Documents Room of Pension and Welfare Benefits Administration, U.S. Department of Labor, room N-5507, 200 Constitution Avenue, NW., Washington, DC 20210.

NOTICE TO INTERESTED PERSONS: Notice of the proposed exemptions will be provided to all interested persons in the manner agreed upon by the applicant and the Department within 15 days of the date of publication in the **Federal Register**. Such notice shall include a copy of the notice of proposed exemption as published in the **Federal Register** and shall inform interested persons of their right to comment and to request a hearing (where appropriate).

SUPPLEMENTARY INFORMATION: The proposed exemptions were requested in applications filed pursuant to section 408(a) of the Act and/or section 4975(c)(2) of the Code, and in accordance with procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type requested to the Secretary of Labor. Therefore, these notices of proposed exemption are issued solely by the Department.

The applications contain representations with regard to the proposed exemptions which are summarized below. Interested persons are referred to the applications on file with the Department for a complete

statement of the facts and representations.

Thomas S. Monaghan, Inc. Tax Deferred Savings Plan (the Plan), Located in Ann Arbor, Michigan

[Application No. D-9122].

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). If the exemption is granted the restrictions of sections 406(a), 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to (1) the proposed extension of credit (the Advances) to the Plan by Thomas S. Monaghan, Inc. (the Company), the sponsor of the Plan, with respect to four guaranteed investment contracts (the GICs) assumed and/or issued by Inter-American Insurance Company of Illinois (Inter-American Illinois); and (2) the potential repayment of the Advances (the Repayments) by the Plan; provided that the following conditions are satisfied:

(a) All terms of such transactions are no less favorable to the Plan than those which the Plan could obtain in arm's-length transactions with an unrelated party;

(b) No interest and/or expenses are paid by the Plan;

(c) The Advances are made only in lieu of payments due from Inter-American with respect to the GICs;

(d) The Repayments shall not exceed the amount of the Advances;

(e) The Repayments shall not exceed the amounts actually received by the Plan from Inter-American Illinois, any state guaranty fund, and other responsible third party payors with respect to the GICs (the GIC Proceeds); and

(f) The Repayment of the Advances shall be waived to the extent that the amount of the Advances exceeds the total GIC Proceeds.

Summary of Facts and Representations

1. The Plan is a defined contribution retirement plan which includes a cash or deferred arrangement under section 401(k) of the Code and which provides for employer matching contributions and additional employer discretionary contributions. As of December 31, 1990, the Plan had approximately 721 participants and total assets of approximately \$4,163,726. The Company

is a Michigan privately-held corporation operating as a holding company with its headquarters in Ann Arbor, Michigan. The Company's subsidiaries are engaged in financing, equipment leasing, real estate acquisition and management, computer software development and active equity investments. The Company maintains the Plan on behalf of its employees and of the employees of its subsidiaries. The participants in the Plan also members of a group of corporations with which the Company is under common control (the Controlled Group). Since November 1, 1990, the trustee of the Plan has been Comerica Bank (the Trustee). Prior to November 1, 1990, the trustee of the Plan was William Brannan (the Predecessor Trustee), an officer of a member of the Controlled Group.

2. The Plan provides for individual participant accounts (the Accounts) and for participant-directed investment of the portion of each Account attributable to employee elective deferrals and matching employer contributions, including earnings thereon. Plan participants direct that portion of their Accounts among various investment options (the Funds) offered by the Plan. Participants' directions and changes of directions, with respect to investments of the Accounts among the Funds, are permitted twice each calendar year, at January 1 and June 30. The Funds include a guaranteed investment fund (the GIC Fund), which invests in guaranteed investment contracts issued by insurance companies. As of December 31, 1990, with assets of \$2,417,656, the GIC Fund comprised 58 percent of the Plan's total assets.

Among the assets in the GIC Fund are the GICs, which are four benefit-responsive guaranteed investment contracts purchased for the Plan by the Predecessor Trustee from 1986 to 1989. Two of the GICs, purchased in 1986 and 1987, were issued by Inter-American Insurance Company, a Delaware corporation whose contracts were assumed by Inter-American Illinois on April 4, 1988. The GICs purchased in 1988 and 1989 were issued by Inter-American Illinois.

Each GIC is a "window" contract which provides that principal deposits over a one-year period will earn interest from the date of issuance (the Issue Date) at rates designated by its terms (the Contract Rates). Under each GIC, the Contract Rate is fixed for the first three-year period of the GIC's term, beginning with the GIC's Issue Date (the Initial Contract Rate). For the remaining term of each GIC, the interest rate is set just before the third anniversary of the Issue Date (the Third Anniversary), and

if such new rate is not at least equal to a pre-established minimal rate (the Subsequent Base Rate), the Plan may withdraw all principal deposits and interest earnings from the GIC (the Pre-maturity Withdrawal). Withdrawals from the GICs may also be made to enable the GIC Fund to effect, in accordance with the terms of the Plan, benefit distributions, in-service withdrawals, participant loans, and participant-directed transfers of Account balances to other investment options offered by the Plan (collectively, the Withdrawal Events).

In addition to withdrawals for the Withdrawal Events and the Pre-maturity Withdrawals, each GIC requires the Inter-American Illinois to make a final payment to the Plan's GIC Fund, upon a maturity date occurring six years from the Issue Date of each GIC, in the amount of the GIC's accumulated book value, representing total principal deposits plus interest earnings at the Contract Rates less previous withdrawals. As of December 31, 1990, the GICs had a total accumulated book value of \$128,069.56, representing total principal deposits plus interest at the Contract Rates less previous withdrawals.

Upon each GIC's Third Anniversary, the Trustee did not effect Pre-maturity Withdrawals of any of the GICs, and each GIC commenced, on its Third Anniversary, to earn interest at a rate in excess of its Subsequent Base Rate. The GICs are further described as follows:

(a) Contract No. B90874, issued June 23, 1986, with an Initial Contract Rate of 8.5 percent, a Subsequent Base Rate of 6.5 percent, a maturity date of June 23, 1992, an accumulated book value of \$28,101.28 as of December 31, 1990, and earning interest after the Third Anniversary at the rate of 7.00 percent;

(b) Contract No. B90948, issued June 6, 1987, with an Initial Contract Rate of 7.0 percent, a Subsequent Base Rate of 5.25 percent, a maturity date of June 8, 1993, an accumulated book value of \$13,499.36 as of December 31, 1990, and earning interest after the Third Anniversary at the rate of 8.50 percent;

(c) Contract No. C90341, issued in 1988, with an Initial Contract Rate of 9.0 percent, a Subsequent Base Rate of 7.0 percent, a maturity date of January 4, 1994, an accumulated book value of \$25,927.91 as of December 31, 1990, and earning interest after the Third Anniversary at the rate of 9.00 percent;

(d) Contract No. C90578, issued January 27, 1989, with an Initial Contract Rate of 9.15 percent, a maturity date of January 27, 1995, an accumulated book value of \$60,541.01 as of December 31,

1990, and earning interest after the Third Anniversary at the rate of 9.15 percent.¹

3. On December 23, 1991, Inter-American Illinois was placed in receivership and ordered to be liquidated by the Circuit Court of Cook County, Illinois, for reasons of insolvency.² Since the commencement of the receivership, payments on all Inter-American Illinois guaranteed investment contracts, including the GICs, have been suspended. Consequently, the GIC Fund has been and remains unable to withdraw amounts from the GICs for Withdrawal Events, and the maturity payment which was due June 23, 1992, under Contract No. B90874 has not been made. The Plan assets attributable to the GIC Fund's investments in the GICs are frozen and Withdrawal Events with respect to Account investments in the GICs are not being funded.

The Company represents that under prevailing circumstances it is unlikely that Inter-American Illinois will make timely payments, or provide the full amounts of principal and interest due, with respect to the GICs. In order to enable the Plan to resume normal operation, and to facilitate the funding of Withdrawal Events, the Company proposes to make the Advances to the Plan. The Company is requesting an exemption to permit the Advances, and their potential Repayments by the Plan, under the terms and conditions described herein.

4. The terms of the Advances and the Repayments are set forth in a written agreement (the Agreement) between the Company and the Trustee, under which the Company agrees to make the Advances to the Plan in such amounts and at such times as withdrawals and maturity payments are due under the GICs. Under the Agreement the amount of each Advance will be determined on the basis of the accumulated book values of the GICs through each GIC's maturity date, representing total principal deposits plus interest earnings at the applicable Contract Rate less previous withdrawals. The Company's obligation to make an Advance under the Agreement with respect to any

Withdrawal Event or maturity payment due under the GICs is reduced by (a) the amount actually received by the Plan from Inter-American Illinois or any state guaranty fund with respect to such withdrawal or maturity payment, and (b) the amount of any previous Advance with respect to such withdrawal or maturity payment. The Employer will receive no interest or fees for the Advances.

In return for the Advances, the Trustee agrees to make the Repayments of the Advances as specified in the Agreement. The Agreement provides that the Repayments will be made only from the proceeds received by the Plan with respect to the GICs from Inter-American Illinois, any other insurer obligated with respect to the GICs, or any state guaranty fund (collectively, the GIC Proceeds). No other Plan assets may be used to repay the Advances. The Agreement becomes effective upon the issuance, if granted, of the final exemption proposed herein by the Department.

5. In summary, the applicant represents that the proposed transaction satisfies the criteria of section 408(a) of the Act for the following reasons: (1) The Plan will be relieved of any further risk or uncertainty with respect to payments due from Inter-American Illinois with respect to the GICs; (2) The proposed transaction will enable the Plan to resume full funding of Withdrawal Events involving Accounts invested in the GIC Fund; (3) The Plan will receive Advances based upon the full accumulated book values of the GICs as of the date of the Advances, representing total principal deposits plus accrued interest at the Contract Rates less previous withdrawals; (4) The Plan will incur no interest or expenses for the Advances; (5) The Repayments will be restricted to the GIC Proceeds; and (6) The Repayments will be waived to the extent the Advances exceed the GIC Proceeds.

FOR FURTHER INFORMATION CONTACT: Ronald Willett of the Department, telephone (202) 523-8881. (This is not a toll-free number.)

Geosonics Inc. 401(k) Profit Sharing Plan (the Plan), Located in Warrendale, Pennsylvania

[Application Nos. D-9017 and D-9018]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). If the exemption is granted, the restrictions of

sections 406(a) and 406(b) (1) and (2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to loans of money to Don Froedge and Monica Froedge, parties in interest with respect to the Plan, from each of their individual accounts in the Plan, provided that the following conditions are met:

1. The terms of the loans are at least as favorable as the Plan could obtain in an arm's-length transaction with an unrelated party;

2. The loans do not exceed 25 percent of the assets of each of the individual accounts throughout the term of the loans;

3. The loans are secured through a promissory note and a perfected security agreement;

4. The fair market value of the collateral securing the loans is established by an independent real estate appraiser; and

5. The collateral is maintained throughout the loan terms at no less than 150 percent of the combined amount of the balance on the two loans and any other encumbrance on the collateral.

Summary of Facts and Representations

1. Geosonics Inc. (the Employer), a subchapter S corporation, is a seismic consulting firm that also manufactures portable seismographs. The Plan is a profit sharing plan that had approximately 39 participants and total assets of \$941,907 as of July 31, 1991. The Plan has a participant loan program which provides that participants may borrow money from their individual accounts for the purpose of purchasing a principal residence.

2. Don Froedge is the president of the Employer and owns 79.6 percent of the outstanding stock of the Employer. Don Froedge and his wife Monica are both participants in the Plan. Don and Monica Froedge would like to borrow money from their individual accounts in the Plan in order to help finance a principal residence. However, because the Employer is a Subchapter S corporation and Don Froedge is a shareholder-employee with respect to the Employer (and Monica Froedge is a "member of the family" of such shareholder-employee), in accordance with the provisions of section 408(d) of the Act, the provisions of section 408(b)(1) of the Act which permit loans to plan participants under certain conditions would not be available in this case.

¹ The Employer represents that a copy of contract No. C90578, which was delivered to the Predecessor Trustee, has been misplaced, and the Subsequent Base Rate for that contract cannot be determined. The Employer represents that the Trustee continues to credit the Accounts invested in this contract with interest of 9.15 percent. The Employer, which is proceeding with efforts to secure a new copy of this contract, represents that its terms and conditions are substantially the same as those of the other GICs.

² The Department notes that the decisions to acquire and hold the GICs are governed by the fiduciary responsibility requirements of part 4, subtitle B, title I of the Act. In this regard, the Department herein is not proposing relief for any violations of part 4 which may have arisen as a result of the acquisition and holding of the GICs.

3. Don Froedge had a vested account balance of \$127,272 as of July 31, 1991, and Monica Froedge had a vested account balance of \$87,778 on the same date. Don Froedge requests a loan of \$31,818 and Monica Froedge requests a loan of \$21,945 from their respective individual accounts in the Plan. In each case, the applicant represents that the loan will not exceed 25 percent of the assets in the individual account throughout the term of the loan. The Plan administrators, Don Froedge and Philip Berger, Jr., will monitor the balances of the loans and the participants' account balances monthly, and prior to any distributions to participants, will insure that the 25 percent limitation is strictly enforced. This will be accomplished by reviewing the monthly statements received from the Plan's investment advisors. If the Plan administrators foresee any event which could cause the 25 percent limitation to be exceeded, the participant will be required to repay a portion of the loan before such excess occurs.

The loans will be for a period of 15 years, with equal monthly payments of principal and interest. The interest rate on the loans will be 9.18 percent per annum. Prior to closing on the loans, the Plan administrators will verify that the rate is still appropriate and will make any adjustment necessary to bring the rate into line with market rates at that time.

4. The administrators of the Plan have obtained a letter from Pittsburgh National Bank (the Bank) dated June 15, 1992, concerning the requested loans. The applicants represent that the Bank is independent of Don and Monica Froedge and the Employer. The Bank states that the applicable interest rate on such loans for a second mortgage position (as described below) is 9.18 percent. The rate takes into account points and closing costs. The Bank concludes that it would make the same loans using the same terms as those described in the application. The Plan will obtain a similar letter from an unrelated commercial lender every five years until the maturity of the loans, and the interest rate on the loans will be adjusted accordingly.

5. The loans will be secured through a promissory note and a security agreement which will be duly perfected under Pennsylvania state law. The two loans together will be secured by a second mortgage on the principal residence (the Property) which was purchased by Don and Monica Froedge in Glasgow, Kentucky, in December 1991. The Plan obtained an appraisal on

the Property from Harold Armstrong (Armstrong), a real estate appraiser located in Glasgow. The applicants represent that Armstrong is not related in any way to Don and Monica Froedge or to the Employer. According to Armstrong, the Property consists of a 130-year old two-story house on approximately 2.1 acres (in one of Glasgow's historic and most desirable neighborhoods) which has been completely renovated within the last year. Using the comparable sales approach to value, Armstrong estimated that the fair market value of the Property was \$310,000 as of September 10, 1991.

6. Don and Monica Froedge secured a first mortgage on the Property from Trans Financial Bank of Glasgow. The amount remaining on the first mortgage was \$135,015 as of May 6, 1992. The applicants represent that the collateral will be maintained throughout the terms of the loans at no less than 150 percent of the combined amount of the balance of the two proposed loans and any other encumbrance on the Property. An independent appraisal of the Property as to its fair market value will be updated annually to verify that the 150 percent collateral requirement is being met. If necessary, the Plan will require the participants to repay a portion of the loans or post additional collateral so as to maintain the 150 percent security for the loans.

Monthly payments on the loans will be made to the individual accounts through payroll deduction to ensure timely payments in full. If payments should become delinquent for more than 60 days, the Plan administrators, in accordance with the procedures outlined in the promissory notes, will take appropriate action on behalf of the accounts, including foreclosing on the collateral if necessary.

7. In summary, the applicant represents that the proposed transactions will satisfy the statutory criteria of section 408(a) of the Act because: (1) A commercial bank independent of the Employer has stated that it would be willing to make the same loans on the same terms; (2) the two loans together will be secured by a second mortgage on the Property; (3) the fair market value of the Property has been established by an unrelated real estate appraiser; and (4) the collateral for the loans will at all times be no less than 150 percent of the combined balance of the loans and any other encumbrance on the Property.

FOR FURTHER INFORMATION CONTACT: Paul Kelly of the Department, telephone

(202) 523-8883. (This is not a toll-free number.)

Tyco Laboratories, Inc. Collective Trust (the Trust), Located in Exeter, New Hampshire

[Application No. D-9132]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). If the exemption is granted, the restrictions of sections 408(a), 408 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to: (1) The interest-free extensions of credit (the Advances) by Tyco Laboratories, Inc. (Tyco), the sponsor of the Trust, to the Trust with respect to Guaranteed Investment Contract No. CG0127303A (the GIC), issued to the Trust by Executive Life Insurance Company of California (ELIC); and (2) the Trust's potential repayment of the Advances (the Repayments); provided that (a) all terms of such transactions are no less favorable to the Trust than those which the Trust could obtain in an arm's-length transaction with an unrelated party, (b) no interest and/or expenses are paid by the Trust, (c) the Advances are made only in lieu of payments due from ELIC and other responsible parties with respect to the GIC (or a Replacement GIC as defined below), (d) the Repayments do not exceed the total amount of the Advances, (e) the Repayments in no event exceed the amounts actually received by the Trust from ELIC and other responsible parties with respect to the GIC, and (f) the Repayments will be waived to the extent the Trust recoups less from or on behalf of ELIC from the disposition of the GIC (or a replacement GIC) than the total amount of the Advances.

EFFECTIVE DATE: If the proposed exemption is granted, it will be effective June 30, 1992.

Summary of Facts and Representations

1. Tyco is a Massachusetts corporation with its principal place of business located in Exeter, New Hampshire. The Trust, established February 18, 1983, forms part of several defined contribution plans (the Plans) which are maintained by Tyco and its

affiliates.³ Investment decisions with respect to Trust assets are currently made by a retirement committee (the Committee) appointed by Tyco's Board of Directors.⁴ As of March 31, 1992, there were total assets of approximately \$133,721,524 in the Trust. The trustee of the Trust is Mellon Bank, N.A.

2. Tyco represents that the GIC bears interest at the rate of 9.61% per annum and as of March 31, 1992, constituted approximately 10.6% of the total assets of the Trust. The maturity date of the GIC is December 31, 1992. Under the terms of the GIC, withdrawals made prior to maturity may be made by the Trust in order to fund the payment of benefits under the Plans or participant-directed investment transfers. As of March 31, 1992, the GIC had an accumulated book value of \$14,149,007, representing total deposits, plus accrued interest, less previous withdrawals.

3. On April 11, 1991, ELIC was placed into conservatorship by the California Insurance Commissioner (the Commissioner). As a result of the commencement of conservatorship, ELIC has ceased all payments with respect to its guaranteed investment contracts, including the GIC.⁵

The Commissioner is proceeding with the development of a plan of rehabilitation (the Rehab Plan) with respect to all of ELIC's outstanding obligations. Under the Rehab Plan as currently proposed, the Trust will be permitted to choose either (i) a lump sum settlement of ELIC's obligations under the GIC, or (ii) an exchange of the GIC for a guaranteed investment or other contract (the Replacement GIC) issued by Aurora National Life Assurance Corporation (Aurora), the successor to certain assets and liabilities of ELIC. Although the exact terms of both arrangements are not yet finalized, Tyco represents that it is expected that the total amount received by the Trust under either option will be less than the accumulated book value of the GIC. Nonetheless, it is anticipated that a greater percentage of the

accumulated book value of the GIC will be received by the Trust if the Replacement GIC option is selected.

4. Tyco represents that the Trust's inability to make withdrawals from the GIC pending settlement or satisfaction of ELIC's obligations thereunder severely impedes benefit distributions from the Plans and will hinder the ability of the Plans to honor participant-directed investment instructions (see footnote 2, above). To protect the participants and beneficiaries in the Plans from any adverse effects of the nonpayment of the GIC or a prolonged rehabilitation or liquidation of ELIC, Tyco proposes to make Advances to the Trust as interest-free loans in such amounts and at such times as are necessary to fulfill the obligations of the Trust and the Plans with respect to benefit distributions and investment transfers pending settlement or satisfaction of ELIC's obligations under the GIC or the Replacement GIC, as the case may be.

5. The proposed transactions are detailed in a written agreement (the Agreement) between Tyco and the Trustee embodying all terms of the extension of credit and its repayment. Under the Agreement, Tyco will make such Advances to the Trust as are necessary to satisfy the short-term liquidity needs of the Trust, including the payment of benefit distributions and investment transfers, pending settlement of the Trust's claims under the GIC.

6. Under the Agreement, the total amount of Advances made by Tyco (less any Repayments as described below) may not exceed, on any date, the then current value (Current Value) of the GIC or the Replacement GIC, as the case may be. For this purpose, the Agreement provides that the Current Value of the GIC or the Replacement GIC, as of any date, means the issue price of the GIC, plus the interest credited or which should have been credited as of such date, less any proceeds received by the Trust on or before such date with respect to the GIC or the Replacement GIC, as the case may be, from ELIC, its successors and assigns, any conservator or trustee of ELIC or other person performing similar functions with respect to ELIC, or by any state guaranty fund or other person or entity (other than Tyco) acting as a surety or insurer with respect to ELIC (collectively, the GIC Payors). For this purpose, the interest which should have been credited shall be 9.61% for the period through December 31, 1992, and interest at the rate set forth in the Replacement GIC for the period commencing on December 31, 1992 and

ending on the date the Replacement GIC matures. If no Replacement GIC is issued and a lump sum settlement of the ELIC GIC is received by the Trust after December 31, 1992, then interest will be credited at 9.61% for the period through December 31, 1992 and, subject to the approval of the Internal Revenue Service under Revenue Procedure 92-16,⁶ interest at the rate paid on money market funds by Mellon Bank, N.A. for the period commencing on December 31, 1992 and ending on the date the lump sum settlement is received.

7. Tyco represents that, under the terms of the Agreement, the Trust will have no obligation to pay any interest to Tyco on account of any Advances made to the Trust. Repayment of the Advances is limited under the Agreement to payments made by any GIC Payor on account of the GIC or the Replacement GIC, as the case may be, and will not exceed the total amount of the Advances. No other assets of the Trust will be available for Repayments. If payments by GIC Payors are not sufficient to fully repay the Advances, Tyco will have no recourse against the Trust or against any participants or beneficiaries of the Plans for the unpaid amount.

8. In summary, the applicant represents that the proposed transactions satisfy the criteria of section 408(a) of the Act for the following reasons: (a) The Trust will be relieved of any further risk and uncertainty with respect to payments due from ELIC under the GIC; (b) the proposed transactions would facilitate benefit distributions and investment transfers under the Plans which would otherwise not be possible because of ELIC's suspension of payments under the GIC; (c) the Repayments by the Trust will not exceed the amounts actually received by the Trust on account of the GIC or the Replacement GIC; and (d) the Repayment of the Advances will be waived to the extent the Trust recoups less from or on behalf of ELIC on the disposition of the GIC (or the Replacement GIC) than the total amount of the Advances.

FOR FURTHER INFORMATION CONTACT:
Gary H. Lefkowitz of the Department,

³ Tyco and/or its affiliates may establish other defined contribution plans, the assets of which may be invested in the Trust. The proposed exemption is intended to cover such plans to the extent they acquire an interest in the GIC or the Replacement GIC (as defined below) through such investment.

⁴ Effective June 30, 1992, the Plans as amended permit participants to direct the investment of their account balances among several investment options specified by the Committee.

⁵ The Department notes that the decisions to acquire and hold the GIC are governed by the fiduciary responsibility requirements of part 4, subtitle B, title I of the Act. In this regard, the Department herein is not proposing relief for any violations of part 4 which may have arisen as a result of the acquisition and holding of the GIC.

⁶ Revenue Procedure 92-16 (I.R.B. 1992-7, February 18, 1992) provides for a temporary closing agreement program to settle certain tax liabilities that arise out of transactions between an employer-sponsor and the trust of a qualified defined contribution plan. This temporary closing agreement program applies to transactions in which the employer makes conditional payments to the plan on account of plan assets that are invested in contracts issued by a life insurance company that has been placed in state insurer delinquency proceedings.

telephone (202) 523-8881. (This is not a toll-free number.)

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest of disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(b) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) Before an exemption may be granted under section 408(a) of the Act and/or section 4975(c)(2) of the Code, the Department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries and protective of the rights of participants and beneficiaries of the plan;

(3) The proposed exemptions, if granted, will be supplemental to, and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction; and

(4) The proposed exemptions, if granted, will be subject to the express condition that the material facts and representations contained in each application are true and complete, and that each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, DC, this 27th day of August, 1992.

Ivan Strasfeld,

Director of Exemption Determinations,
Pension and Welfare Benefits Administration,
U.S. Department of Labor.

[FR Doc. 92-20989 Filed 8-31-92; 8:45 am]

BILLING CODE 4510-29-M

NATIONAL COMMISSION ON AMERICA'S URBAN FAMILIES

Meeting

Notice is hereby given, pursuant to Public Law 92-463, that the National Commission on America's Urban Families will hold a roundtable discussion and site visits in Knoxville, Tennessee, on Tuesday, September 15, 1992. For exact time and locations, please contact the Commission two days prior to the event at 202-690-6462.

The purpose of the roundtable and site visits is to gather information about programs and approaches that work to strengthen families.

Records shall be kept of all Commission proceedings and shall be available for public inspection at 200 Independence Avenue, SW., room 305-F, Washington, DC 20201.

Anna Kondratas,

Executive Director.

[FR Doc. 92-21104 Filed 8-31-92; 8:45 am]

BILLING CODE 4150-01-M

NATIONAL SCIENCE FOUNDATION

Ocean Sciences Review Panel; Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92-463, as amended), the National Science Foundation (NSF) announces the following meetings.

Date and Time: September 18, 1992; 8:30 a.m. to 5 p.m.

Place: Room 500B, NSF, 1800 G Street NW., Washington, DC.

Contact Person: Rodger Baier, Associate Program Director, Division of Ocean Sciences, Rm. 609, National Science Foundation, 1800 G St. NW., Washington, DC 20550. Telephone: (202) 357-7910.

Agenda: To review and evaluate Small Business Innovation Research proposals as part of the selection process for awards.

Date and Time: September 15, 1992; 8:30 a.m. to 5 p.m.

Place: Room 500C, NSF, 1800 G Street NW., Washington, DC.

Contact Person: Richard W. West, Program Director, Division of Ocean Sciences, Rm. 609, National Science Foundation, 1800 G Street NW., Washington, DC 20550. Telephone: (202) 357-9639.

Agenda: To review and evaluate Intermediate Ship Mid-Life proposals as part of the selection process for awards.

Type of Meetings: Closed.

Purpose of Meetings: To provide advice and recommendations

concerning support for research proposals submitted to the NSF for financial support.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c) (4) and (6) of the Government in the Sunshine Act.

Dated: August 26, 1992.

Modestine Rogers,

Acting Committee Management Officer.

[FR Doc. 92-20964 Filed 8-31-92; 8:45 am]

BILLING CODE 7555-01-M

NUCLEAR REGULATORY COMMISSION

[Docket No. 030-04632; License No. 20-03529-01]

Interstate Nuclear Service Corporation, Indian Orchard, Massachusetts; Receipt of Petition Under 10 CFR 2.206

Notice is hereby given that, by Petition dated June 29, 1992, Gloria M. Mitchell and Linda Hammons, on behalf of the Indian Orchard Citizens Council, requested that the Nuclear Regulatory Commission take action with regard to Interstate Nuclear Service Corporation (INS). Petitioners request that the NRC: participate in a public hearing in Indian Orchard to respond to the concerns of neighborhood residents; hold a surprise inspection of INS; check homes in the area for radiation contamination; provide a copy of the NRC regulations under which INS operates; check adjoining Park Department land, including Dimmock Pond and Loon Pond, for contamination and illegal dumping of waste material; determine what INS has done with waste material not shipped; provide the docket number for INS; identify a Public Document Room for INS and its location; and describe the type of monitoring done, who does it, and how frequently. Petitioners further request on behalf of neighborhood residents that: Radioactive readings outside the INS fence perimeters be "0" at all times; "0" nuclear waste by-products be allowed to enter Springfield's water/sewer system; INS stop using residential streets, specifically Nagle and Nichols Streets, to go to and from its plant; and under no circumstances should INS be allowed to store nuclear waste on its property.

Petitioners assert as bases for these requests that the residents of the Indian Orchard neighborhood of Springfield, Massachusetts, live in close proximity to INS and have expressed great concern over possible health issues, especially since publication of an article in the Springfield Sunday Republican on June 7, 1992, which reported that: Radiation readings outside the INS perimeter fence, near a waste-filled truck, were 12 to 15 times normal background radiation levels experienced in everyday life; all INS waste will be stored on site beginning January 1, 1993; in 1989 INS waste stored was twice the volume shipped; the corporate health physics manager of INS, Michael Bovino, said that waste is removed twice a year but NRC records indicate it is removed only once a year and not at all in 1990; a person standing at the INS fence for two days in early May would have received a higher radiation dose than a person standing at Vermont Yankee's fence for a year because of stiffer regulations for nuclear power plants; and there have been allegations that INS discharges radioactive water into the City sewer system.

The Petition has been referred to the Director of the Office of Nuclear Material Safety and Safeguards pursuant to 10 CFR 2.206. As provided by § 2.206, appropriate action will be taken with regard to the specific issues raised by the petition in a reasonable time.

A copy of the Petition is available for inspection at the Commission's Public Document Room at 2110 L Street, NW., Washington DC 20555, and at the Local Public Document Room for the INS facility located at the Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

Dated at Rockville, Maryland this 25th day of August, 1992.

For the Nuclear Regulatory Commission.
Robert M. Bernero,
Director, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 92-20973 Filed 8-31-92; 8:45 am]

BILLING CODE 7590-01-M

Availability of Staff Technical Position on the Investigation of Fault Displacement Hazards and Seismic Hazards at a Geologic Repository

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability.

SUMMARY: The Nuclear Regulatory Commission is announcing the

availability of NUREG-1451, "Staff Technical Position (STP) on Investigations to Identify Fault Displacement Hazards and Seismic Hazards at a Geologic Repository."

ADDRESSES: Copies of NUREG-1451, including the staff disposition of comments, can be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 37082, Washington, DC 20013-7082. Copies are also available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. A copy of NUREG-1451 is also available for public inspection and/or copying at the NRC Public Document Room, 2120 L Street (Lower Level), NW., Washington, DC 20555.

FOR FURTHER INFORMATION CONTACT: Anne E. Garcia, Repository Licensing and Quality Assurance Project Directorate, Division of High-Level Waste Management Office of Nuclear Material Safety and Safeguards, Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, MD 20852. Telephone 301/504-2438.

SUPPLEMENTARY INFORMATION: 10 CFR part 60 does not specify the manner in which potential fault displacement hazards and seismic hazards at a candidate site for a geologic repository are to be identified. The purpose of this STP, therefore, is to provide guidance to the DOE on acceptable geologic repository investigations that can be used to identify fault displacement hazards and seismic hazards. The staff considers that the approach this STP takes to investigations of fault displacement and seismic phenomena is appropriate for the collection of sufficient data for input to analyses of fault displacement hazards and seismic hazards, both for the preclosure and postclosure performance periods. However, detailed analyses of fault displacement and seismic data, such as those required for comprehensive assessments of repository performance, may identify the need for additional investigations.

Guidance on methods of analysis of fault displacement hazards and seismic hazards at a geologic repository is being developed separately.

On August 24, 1989, the Nuclear Regulatory Commission published, in the Federal Register, the "Notice of Availability" for the draft Technical Position (TP) on "Methods of Evaluating the Seismic Hazard at a Geologic Repository" and solicited public comments (see 54 FR 35266).

Approximately 40 comments were received from three different parties. On

December 19-20, 1989, the staff conducted a technical exchange with DOE, the State of Nevada, and DOE program participants to discuss the intent of the draft TP and related topics. Following the December 1989 technical exchange, and a review of the public comments, significant changes and clarifications were incorporated into the draft TP. (Staff responses to the public comments were documented separately as an appendix to the draft TP.)

On February 20, 1991, the NRC staff conducted a second technical exchange with DOE, the State of Nevada; Nye County, Nevada; and the Edison Electric Institute, to discuss the revised 1989 draft TP and the staff's response to public comments. In light of the additional comments received at the technical exchange, and because the revised TP contained significant revisions, the staff decided to make the revised TP available again for public comment.

On May 13, 1991, NRC published the "Notice of Availability" for the draft TP in the Federal Register (see 56 FR 22020), now renamed "Staff Technical Position on Investigations to Identify Fault Displacement and Seismic Hazards at a Geologic Repository" and solicited public comments. As a result, more than 80 comments were received from five different parties. The NRC staff reviewed these comments and, as a result, changes and clarifications were incorporated into the STP. Staff responses to these comments are documented separately as appendix E to NUREG-1451.

On December 18, 1991, the NRC staff briefed the Advisory Committee on Nuclear Waste (ACNW) on the revised STP following the end of the public comment period. As a result, the staff received a number of comments from the ACNW. The staff's responses to these comments are documented separately, as Appendix F to NUREG-1451.

Also included in NUREG-1451 is the staff response to a set of comments, dated February 27, 1990, submitted by DOE after the December 19-20, 1989, technical exchange. These comments were considered, along with the public comments made on the May 1991 draft STP. Staff responses to DOE's February 1991 comments are documented separately, as appendix D to NUREG-1451.

Dated at Rockville, Maryland this 8th day of June, 1992.

For the Nuclear Regulatory Commission.
Robert M. Bernero,
*Director, Office of Nuclear Material Safety
 and Safeguards.*
 [FR Doc. 92-20975 Filed 8-31-92; 8:45 am]
 BILLING CODE 7590-01-M

[Docket No. 50-213]

**Connecticut Yankee Atomic Power
 Company; Consideration of Issuance
 of Amendment to Facility Operating
 License and Opportunity for Hearing**

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License No. DPR-61, issued to Connecticut Yankee Atomic Power Company (the licensee), for operation of the Haddam Neck Plant located in Middlesex County, Connecticut.

The proposed amendment would modify the existing steam generator tubes repair (plugging/sleeving) limits in the Technical Specifications. The licensee justified the proposed change based on a combination of enhanced inservice inspection, a repair limit based on crack length rather than crack depth and a limit on the number of tubes with characterized cracks retained in service.

Before issuance of the proposed license amendment, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

By October 1, 1992, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR part 2. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555 and at the local public document room located at the Russell Library, 123 Broad Street, Middletown, Connecticut 06457. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing

Board Panel, will rule on the request and/or petition; and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made a party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to fifteen (15) days prior to the first pre-hearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one

contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Services Branch, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555, by the above date. Where petitions are filed during the last ten (10) days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at 1-(800) 325-6000 (in Missouri 1-(800) 342-6700). The Western Union operator should be given Datagram Identification Number N1023 and the following message addressed to John F. Stolz: petitioner's name and telephone number; date petition was mailed; plant name; and publication date and page number of this Federal Register notice. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to Gerald Garfield, Esquire, Day, Berry & Howard, Counselors at Law, City Place, Hartford, Connecticut 06103-3499, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)-(v) and 2.714(d).

If a request for a hearing is received, the Commission's staff may issue the amendment after it completes its technical review and prior to the completion of any required hearing if it publishes a further notice for public comment of its proposed finding of no significant hazards consideration in accordance with 10 CFR 50.91 and 50.92.

For further details with respect to this action, see the application for amendment dated July 31, 1992, which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW.,

Washington, DC 20555, and at the local public document room located at the Russell Library, 123 Broad Street, Middletown, Connecticut 06457.

Dated at Rockville, Maryland, this 25th day of August 1992.

For the Nuclear Regulatory Commission.
John F. Stolz,

Project Directorate I-4, Division of Reactor Projects—1/II, Office of Nuclear Reactor Regulation.

[FR Doc. 92-20976 Filed 8-31-92; 8:45 am]

BILLING CODE 7590-01-M

(Docket No. 030-13204, License No. 21-00864-02 EA 91-017)

Lafayette Clinic, Detroit, MI; Order Imposing Civil Monetary Penalties

I

Lafayette Clinic (licensee) is the holder of Byproduct Material License No. 21-00864-02 issued by the Nuclear Regulatory Commission (NRC or Commission) on September 13, 1977. The license was most recently amended in its entirety on December 21, 1990, and is due to expire on January 31, 1996. The license authorizes the licensee to possess and use a limited number of radioisotopes in millicurie quantities for in-vitro laboratory research studies in accordance with the conditions specified therein.

II

An inspection of the licensee's activities was conducted October 3 through 24, 1988. The results of this inspection and a subsequent investigation conducted by the NRC Office of Investigations (OI) indicated that the licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and proposed Imposition of Civil Penalties (Notice) was served upon the licensee by letter dated October 3, 1991. The Notice states the nature of the violations, the provisions of the NRC's requirements that the licensee had violated, and the amount of the civil penalties proposed for the violations. The licensee responded to the Notice by letter dated November 1, 1991. In its response, the licensee admitted Violations I.A. and III.A-I and denied Violations I.B., II.A, and II.B. Additionally, the licensee requested a change in severity levels for Violations I.B and II.A, and requested mitigation of the base civil penalty for Violations I.B and II.B.

III

After consideration of the licensee's response and the statements of fact,

explanation, and argument for mitigation contained therein, as well as all information concerning these matters available to date, the NRC staff has determined, as set forth in the Appendix to this Order, that: (1) Violations II.A and II.B did occur (Violation II.B is amended as stated in the Appendix); (2) Consistent with a settlement agreement between the NRC staff and Dr. Natraj Sitaram where Violation I.B. was withdrawn, the cumulative amount of the proposed civil penalties should be reduced by \$4,000 based on the withdrawal of Violation I.B.; (3) the licensee has not provided an adequate basis for any further reduction in the amount of the civil penalties; and (4) civil penalties in the cumulative amount of \$7,500 should be imposed.

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, it is hereby ordered that:

The licensee pay civil penalties in the cumulative amount of \$7,500 within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555.

V

The licensee may request a hearing within 30 days of the date of this Order. A request for a hearing should be clearly marked as a "Request for an Enforcement Hearing" and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region III, 799 Roosevelt Road, Glen Ellyn, Illinois 60137.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the licensee fails to request a hearing within 30 days of the date of this Order, the provisions of this order shall be effective without further proceedings. If a hearing has not been requested and payment has not been made by that time, the matter may be referred to the U.S. Attorney General for collection.

In the event the licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

(a) Whether the licensee was in violation of the Commission's requirements as set forth in Violation II.A of the Notice referenced in Section

II above the Violation II.B. as amended in the Appendix to this Order, and

(b) Whether, on the basis of such violations, this Order should be sustained.

Dated at Rockville, Maryland this 21st day of August 1992.

For the Nuclear Regulatory Commission
James Lieberman,
Director, Office of Enforcement.

Appendix—Evaluations and Conclusions

On October 3, 1991, a Notice of Violation and Proposed Imposition of Civil Penalties (Notice) was issued for violations identified during an NRC inspection on October 3 through October 24, 1988, and a subsequent investigation conducted by the NRC Office of Investigations (OI). Lafayette Clinic responded to the Notice through the Attorney General of the State of Michigan in a letter dated November 1, 1991. In its response, the licensee admitted Violations I.A. and III.A-III.I and denied Violations I.B, II.A, and II.B. Additionally, the licensee requested a change in severity levels for Violations I.B. and II.A, and requested mitigation of the base civil penalty for Violations I.B and II.B. The NRC's evaluation and conclusions regarding the licensee's requests are as follows:

Restatement of Violation I.B.

License Condition No. 12, as contained in Amendment No. 5, dated April 6, 1988, states that licensed materials listed in subitems A. through I. shall be used by, or under the supervision of Kenneth Warner, Eugene L. Dembicki, or Lew Hryhorczuk.

Contrary to above, Dr. Sitaram used phosphorus-32, a licensed material listed in Subitem E., on June 18 and 19, 1988, and was not under the supervision of Messrs. Warner, Dembicki, or Hryhorczuk.

Summary of Licensee's Response to Violation I.B.

Briefly stated, the licensee believes that the use of phosphorous-32 did occur on June 18-19, 1988, but that this use was authorized by the RSO and was therefore not a violation; and even if the use was not authorized, the resulting violation should be categorized, in accordance with the examples in the NRC Enforcement Policy, at Severity Level III instead of Severity Level II.

NRC Evaluation of Licensee's Response

After the Notice was issued and as a result of a hearing request by Dr. Natraj Sitaram in connection with an Order Modifying License (Effective Immediately) dated October 3, 1991 (EA 91-130), which is related to this issue, the NRC staff continued to evaluate the circumstances described in Violation I.B. Although the NRC staff does not find the licensee's arguments to be persuasive, upon further consideration of all relevant information, including information received following the OI investigation, the NRC staff decided to withdraw Violation I.B. in connection with a settlement agreement between the NRC staff and Dr. Natraj Sitaram. Since Violation I.B. was assessed at

\$4,000, the cumulative amount of the civil penalties is being reduced by \$4,000.

Restatement of Violation II.A

10 CFR 30.7(a) states that discrimination by a Commission licensee, an applicant for a Commission license, or a contractor or subcontractor of a Commission licensee or applicant against an employee for engaging in certain protected activities is prohibited. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, and privileges of employment.

Contrary to above, on August 26, 1988, Lafayette Clinic's Radiation Safety Officer (RSO) was informed that he was to be removed on September 1, 1988 from the Radiation Safety Committee and from his position as RSO by the Acting Director for conducting an internal investigation during June 1988, into the possible unauthorized procurement and use of phosphorus-32 at the Clinic and for his identification of an apparent discriminatory firing by a researcher of a research assistant.

Summary of Licensee's Response to Violation II.A

The licensee denies the violation. The licensee submits that Dr. Rosenzweig of Wayne State University made the decision as to who would be on the Radiation Safety Committee and who would be the RSO as part of the negotiations for Wayne State University to take over control of research laboratories at Lafayette Clinic. According to the licensee, the RSO did not appear on the July 8, 1988, list of proposed committee members (the list was proposed by Dr. Rosenzweig of Wayne State University); and, although Dr. Sitaram's name appears on the proposed list, there is no evidence that Dr. Rosenzweig knew of the alleged violation of licensed requirements by Dr. Sitaram at the time he made this proposal nor is there evidence that he knew that the RSO was in fact conducting an investigation.

The licensee further states that: (1) The RSO did not complain that he was discriminated against; (2) the RSO's responsibilities included ensuring that radioactive material is used by or under the direct supervision of individuals specifically listed on the license; (3) the RSO failed to ensure that Dr. Sitaram did not use radioactive material outside the direct supervision of the individuals named in the license; (4) the RSO also failed to ensure that personnel monitoring equipment was provided to individuals during the experiments conducted by Dr. Sitaram, and failed to ensure that radioactive materials were properly secured after he learned that, on or about May 31, 1988, radioactive materials had been inappropriately brought into the premises; (5) the RSO did not ensure that the terms and conditions of the license were met and that all required records were maintained; (6) the NRC rejects any implication that the RSO had failed to perform his job adequately; (7) it is clear, from the findings made by the NRC, that there was ample reason to remove the RSO from his position; (8) Lafayette Clinic did not remove the RSO for any reason connected with the Radiation Safety Committee, the

Radiation Safety Program, or the license issued by the NRC; (9) at the time of the RSO's removal, the only reason for the removal was the proposed transfer of authority over research laboratories to Wayne State University and the desire of the University to name other individuals to positions of responsibility in relation to research activity; and (10) what the licensee terms "NRC's speculative statements" such as "it appears unnecessary to have replaced the RSO for this short period of time unless discrimination was the motivating factor," should be given equal weight to the countervailing conjecture that Lafayette Clinic, which had already internally identified what it considered to be a possible act of discrimination by Dr. Sitaram against his research assistant, would be unlikely to totally disregard that situation and discriminate against the RSO regarding the same incident.

NRC Evaluation of Licensee's Response

Lafayette Clinic is the licensee in this matter. The NRC staff rejects the assertion that an outside entity (such as Dr. Rosenzweig of Wayne State University, or Ms. Censoni, the Director of Psychiatric Hospitals) may make the decision as to who would be on the Radiation Safety Committee and who would be the RSO at Lafayette Clinic. The circumstances of the pending takeover of Lafayette Clinic by Wayne State University notwithstanding, under the terms of the NRC License issued to Lafayette Clinic, the senior licensee official, Dr. Sullivan, was responsible for making the final decision in this matter and was accountable for all decisions regarding the organization of the Radiation Safety Committee and who would be RSO at Lafayette Clinic during the time period in question. If, in fact, Lafayette Clinic transferred management control of licensed activities to Wayne State University by permitting Dr. Rosenzweig to direct licensed activities, such as determining who should be RSO, then that transfer would be a separate violation of the Atomic Energy Act and would be subject to additional sanction.

While Lafayette Clinic, as the licensee, remains responsible, the NRC does not dispute that Lafayette Clinic may have been influenced by Dr. Rosenzweig in this matter, or that the impetus for the discretionary activity may have come from, or through, Dr. Rosenzweig. The reconstitution of the Radiation Safety Committee, which was done at the request of Dr. Rosenzweig, added Dr. Sitaram and concomitantly left out the RSO, who had been a member of the committee up until that time. Dr. Sitaram was the subject of the RSO's investigation concerning potential violations of Lafayette Clinic radiation safety procedures, and had been warned by the RSO that, under the extent circumstances, firing a research assistant could constitute discrimination under the Commission's regulations. According to the minutes of the August 15, 1988 meeting of the Radiation Safety Committee, which show that Dr. Sullivan was present, Dr. Sitaram was not cooperating with the committee by responding to the committee's written questions concerning the potential violations. In fact, the minutes state that Dr. Sullivan

intended to elevate this matter to Dr. Rosenzweig by the end of that week. Dr. Sitaram, in his sworn, transcribed statement to the NRC Office of Investigations (OI), admits that he never did respond to the committee's questions. Despite these facts, Dr. Sullivan reconstituted the committee on August 26, 1988, adding Dr. Sitaram and deleting the RSO. It is this action against the RSO that constitutes the basis for the violation. Such treatment, in particular since it occurred in full view of the members of the Radiation Safety Committee, can only result in the message that persons raising safety issues will not be supported by the licensee.

The NRC staff disagrees with the licensee's statement that there is no evidence that Dr. Rosenzweig had knowledge of the potential violations attributable to Dr. Sitaram and the RSO's investigation into those matters at the time that Dr. Rosenzweig made his July 8, 1988 request for reconstitution of the Radiation Safety Committee. For example, the RSO's memorandum dated June 30, 1988, addressed to Dr. Rosenzweig and others, is evidence that Dr. Rosenzweig had knowledge of the pending issues involving Dr. Sitaram and the RSO. Further, Dr. Rosenzweig, in his sworn, transcribed statement to OI, stated:

"... [w]hen [the research assistant] learned that he [Dr. Sitaram] was using radioisotopes ... she went to [the RSO] and asked for a radiation badge and he got her a radiation badge. But he also blew a gasket, because this was the first he knew that Sitaram was doing this. Then he created a storm in a teacup, giving Sitaram a citation for having brought this material in the improper way."

When asked by the OI investigator how he became aware of the allegation that Dr. Sitaram improperly used radioactive material a second time, Dr. Rosenzweig responded: "I was getting the repercussions. I was getting the noise coming over from the clinic." Dr. Rosenzweig continues, "... I said to [Dr.] Sullivan, we can't go on like this ... I said to [Dr.] Sullivan, I want all the researchers who have had experience with radioisotopes to furnish me with that experience in writing ... Dr. Rosenzweig attached the information on the researchers' experience to his July 8, 1988, memorandum requesting that the Radiation Safety Committee be reorganized. Thus, the NRC staff can date Dr. Rosenzweig's knowledge of the potential violations attributable to Dr. Sitaram and the RSO's investigation into those matters."

Regarding the licensee's argument that the RSO did not complain that he was discriminated against to anyone, 10 CFR 30.7 does not require the employee who is discriminated against to believe that discrimination has occurred or to come forth with a complaint of discrimination in any manner. Further, the RSO, in his sworn, transcribed statement to OI, stated:

"I believe that the reason that I was replaced as the RSO was because I was pressuring the administration with respect to the Sitaram issue ... after I received a dismissal from the Radiation Safety Officer [position] ... I talked to Dr. Sullivan and he clearly told me ... 'we don't want to challenge Dr. Rosenzweig on this one.' I

didn't go to get a grievance out of that because I still had the other grievance in operation * * * so I figured as that proceeds, all of this would come out.

The NRC staff adheres to its reasoning that, since the Wayne State University RSO was to take over the RSO function at Lafayette Clinic after the reorganization, it appears unnecessary to have replaced the RSO at Lafayette Clinic for what was then believed to be a very short interim period, unless discrimination was the motivating factor. The licensee's countervailing argument is that it would be unlikely to sanction discrimination against the RSO when it had just recently identified what it considered to be a possible act of discrimination by Dr. Sitaram against his research assistant. In point of fact, however, it was the RSO who identified the discrimination issue regarding Dr. Sitaram and the research assistant, and it was the licensee that did not take effective steps to correct that problem, just as the licensee did not take effective steps to assure that discrimination against the RSO did not occur.

By the licensee's own admission, the argument that the RSO performed poorly is not relevant to the action that the licensee took in this matter and therefore need not be addressed in detail. In its November 1, 1991 response (p. 15), the licensee states that it " * * * did not remove the RSO for any reason connected with the Radiation Safety Committee, the Radiation Safety Program, or the license issued by the NRC." Likewise, Dr. Sullivan's letter to NRC dated November 18, 1991, states " * * * [The RSO] was not removed because of poor performance." Further, there is no documentation of the RSO's poor performance or evidence of counseling (e.g., a letter of reprimand or poor performance appraisal), and in Dr. Sullivan's August 26, 1988, memorandum removing the RSO, Dr. Sullivan commended the RSO for his hard work and stated he was surprised that the removal was occurring at this time.

Accordingly, the NRC maintains that the RSO was involved in a protected activity, that adverse action was taken against the RSO as a result of his involvement in the protected activity, and that the licensee's arguments are without merit and do not provide a basis for withdrawing the violation.

Summary of Licensee's Request for Change in Severity Level

The Licensee also argues that if Dr. Sullivan did discriminate against the RSO, it would not be a Severity Level I violation. According to the licensee, based on the examples in the NRC Enforcement Policy, Supplement VII, Dr. Sitaram was a first-line supervisor, Dr. Sullivan was plant management, and Diana Censoni or the Director of the Department of Mental Health was senior corporate management. Thus, the alleged act of discrimination against the RSO should be characterized as Severity Level II and the penalty assessed should be \$4,000.

NRC Evaluation of Licensee's Request for Change in Severity Level

As previously stated, Lafayette Clinic is the licensee. Dr. Sullivan is considered to be senior corporate management because he

was the most senior licensee individual. Therefore, NRC concludes that Violation II.A was appropriately categorized at Severity Level I and that the civil penalty should be \$5,000.

Violation II.B, as Originally Stated

10 CFR 30.7(a) states that discrimination by a Commission licensee, an applicant for a Commission license, or a contractor or subcontractor of a Commission licensee or applicant against an employee for engaging in certain protected activities is prohibited. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, and privileges of employment.

Contrary to above, on June 20, 1988, a research assistant's employment was terminated by her supervisor as a result of her expressing concern to the RSO about the radiation exposure she was receiving at the Clinic and her request to the RSO for a radiation monitoring badge.

Restatement of Violation II.B, as Amended

As restated below, Violation II.B is modified to include additional facts concerning the discrimination against the research assistant and to correct the date of the termination of the research assistant:

10 CFR 30.7(a) states that discrimination by a Commission licensee, an applicant for a Commission license, or a contractor or subcontractor of a Commission licensee or applicant against an employee for engaging in certain protected activities is prohibited. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, and privileges of employment.

Contrary to above, beginning on June 7, 1988 and extending through July 20, 1988, a research assistant, who worked in an area of the licensee's facility where licensed material was being used, was discriminated against as a result her actions on June 6, 1988, when she expressed concern to the licensee's RSO about the radiation exposure she was receiving at the licensee's facility and requested that the RSO provide her with a radiation monitoring badge. Specifically, during this time period, the research assistant did not receive the wages due to her; and she was informed by, or at the behest of, her supervisor that she was being terminated on a number of occasions including June 13, 1988 (the ultimate termination occurred by memorandum dated July 20, 1988). Individually and severally, these actions against the research assistant constitute discrimination for engaging in protected activity.

Summary of Licensee's Response to Violation II.B

The licensee denies the violation. The licensee submits that: (1) The investigative report of the Michigan Department of Labor is not a finding of any sort even though, according to the licensee, the NRC, in its October 3, 1991, letter accompanying the Notice, has characterized it as such; (2) there was no evidentiary hearing regarding this matter; and (3) there was not a determination by any administrative officer of the Michigan Department of Labor that the allegations made by the research assistant were accurate. According to the licensee, the

matter involved a Wayne State University professor (Dr. Sitaram) and a Wayne State University student (the research assistant) who used research facilities at Lafayette Clinic. The licensee further asserts that the research assistant was an employee of Dr. Sitaram, not an employee of the licensee.

According to the licensee: (1) The NRC's reliance on the licensee's failure to provide any evidence of poor performance by the research assistant is an example of an attempt to switch the burden of proof to the licensee in this matter; whereas the investigation was conducted by the NRC, and the burden of proof with regard to alleged license violations should be with the NRC; (2) Wayne State University resolved this matter with the research assistant by the entry of a consent order involving a Michigan Department of Labor complaint that she had filed, and this document specifically indicates that it is not to be construed as an admission of liability on behalf of either party; (3) the research assistant was not in the process of commencing, causing to commence, or about to commence any proceeding under the Atomic Energy Act of 1954, was not about to testify in any such proceeding, and had not assisted or participated in any action to carry out purposes of the Atomic Energy Act since her sole activity with regard to this matter was to ask for a ring monitor so that she could be protected against exposure to radiation during her laboratory work; and (4) the research assistant was not reporting unauthorized activity, she did not know whether the activity was authorized or not, and it was the RSO who investigated and determined that unauthorized activity had taken place.

NRC Evaluation of Licensee's Response

NRC acknowledges that there was no evidentiary hearing or formal adjudicatory determination that the allegations made by the research assistant were accurate. However, the facts and conclusions of the Michigan Department of Labor investigation were considered by NRC in issuing Violation II.B, as were the results of the enforcement conference that NRC held with the licensee. 10 CFR 30.7 prohibits discrimination against an employee by Commission licensees and their contractors or subcontractors. In this case, the protected activity occurred in connection with the conduct of licensed activities under the NRC license issued to Lafayette Clinic. Therefore, it is appropriate to hold Lafayette Clinic responsible for the violations regardless of whether or not Wayne State University might be the employing entity. With regard to whether the research assistant was engaged in protected activity within the meaning of the Commission's regulations, the NRC considers a request by an employee to his or her management for equipment designed to monitor the individual's exposure to radiation to be protected activity.

The facts as determined by the NRC staff are that: (1) The research assistant requested the radiation monitoring badge on June 6, 1988; (2) that same day, the RSO, acting on the information provided by the research assistant, confronted Dr. Sitaram concerning

his unauthorized use of phosphorus-32; (3) on June 7, 1988, Dr. Sitaram told the research assistant that there would be no work for her since the RSO would not allow him to work with radioactive material; (4) on June 13, 1988, Dr. Sitaram had Drs. Dube and Grabowski tell the research assistant that she was being terminated, but later that day Dr. Sitaram told her that he might give her a second chance; (5) during the period June 1988-July 20, 1988, the research assistant did not receive any wages due to her; and (6) the research assistant was formally notified of her termination by memorandum dated July 20, 1988.

Dr. Sitaram, in his letter to NRC dated November 25, 1991, states:

I realized that the Lafayette Clinic patient samples processed by [the research assistant] were seriously degraded. [She] had apparently been processing many samples in the way she had been used to before for plasmid preparations and consequently had caused considerable shearing of human high molecular weight DNA. . . . I emphasize also that my expressed concerns [to the research assistant regarding the technique that she used to process laboratory samples] were made much before her very legitimate request. . . . for a radiation safety badge on June 6 [1988] (emphasis in original).

It is clear from the exhibits to the OI investigation that the discussions regarding the termination of the research assistant occurred only after her request for the radiation badge. If the termination was based on her alleged poor technique in processing laboratory samples, then the subject of termination would have been raised before the request for the radiation monitoring badge.

In Exhibit 14 of Dr. Sitaram's November 25, 1991, letter (consisting of a typewritten memorandum to Dr. Rosenzweig from Dr. Sitaram with handwritten annotations by Dr. Sitaram), Dr. Sitaram states that he did not obtain autoradiography results on the laboratory work until the last of June. Dr. Sitaram indicates that the autoradiography results were disappointing, but "[s]ince the process consists of a chain of procedures. . . it would be unfair to blame a single person for the disappointing result." He further indicates that the disappointing autoradiography results led him, in discussion with his colleagues, to change the direction of his research; and that it was this change in direction that made the job held by the research assistant no longer necessary, thus leading to her termination.

Dr. Rosenzweig, in his sworn, transcribed statement to OI, also dates the decision to change the direction of the research to Dr. Sitaram's return from Gaithersburg, Maryland. Dr. Sitaram indicates in his November 25, 1991 letter to NRC that he left Gaithersburg on June 27, 1988.

In sum: (1) The performance of the research assistant in processing the samples was substantially known well before she requested a radiation monitoring badge; (2) she was not informed that she was being terminated until after she requested a radiation monitoring badge; and (3) the decision to change the direction of the research did not occur until well after the

research assistant was informed that she was being terminated. Based on this chain of events, the NRC staff concludes that the aforementioned treatment of the research assistant between June 6 and July 20, 1988, constitutes discrimination for engaging in a protected activity.

Therefore, the NRC staff concludes that the licensee's argument is without merit and does not provide a basis for withdrawing the violation.

Summary of Licensee's Request for Mitigation

With regard to the discrimination against the research assistant, the licensee submits that: (1) There was prompt identification and reporting, and intervention of officials at Wayne State University regarding her termination; (2) the RSO counseled Dr. Sitaram regarding his action involving the research assistant and promptly reported it to the Director of Lafayette Clinic; and (3) there were no prior incidents of this nature in the history of Lafayette Clinic and it was a single event. According to the licensee, its prior good past performance in this area was disregarded by the NRC, as was the licensee's subsequent refusal to allow Dr. Sitaram to conduct experiments using the Lafayette Clinic facility. In sum, the licensee claims that there was prompt identification and reporting, there was corrective action to prevent recurrence, this was a singular event, and the past performance of the licensee was exemplary. In the opinion of the licensee, under these conditions, the base civil penalty assessed against the licensee should be reduced by 50% to \$1,250.

NRC Evaluation of Licensee's Request for Mitigation

Violation II.B was not a reportable event. Although the threatened termination was identified by the RSO as a potential violation in the RSO's June 14, 1988 memorandum to Dr. Fischhoff, who was acting in the absence of Dr. Rosenzweig, a pattern of retaliation for the research assistant's exercise of protected activities continued, culminating in her termination in violation of NRC requirements. Mitigation is not warranted for extensive corrective action because the licensee's actions were not prompt and extensive in assuring that all employees understand their rights to raise safety issues without fear of discrimination. In addition, NRC does not generally mitigate civil penalties for good past performance when a willful violation is involved. Discrimination is considered to be willful. Additionally, no mitigation is warranted for the singular nature of the occurrence. In accordance with section V.B.5 of the NRC Enforcement Policy (1988), the base civil penalty may be increased as much as 50% where multiple examples of a particular violation are identified; however, there is no provision for mitigation for singular occurrences. Therefore, the NRC concludes that no mitigation is warranted for Violation II.B.

NRC Conclusion

Based on its evaluation of the licensee's response, the NRC staff concludes that Violations II.A and II.B did occur as stated, and that the licensee's arguments for

mitigation of base civil penalties and changes to severity levels are without merit. Accordingly, NRC concludes that a civil monetary penalty of \$7,500 should be imposed by order.

[FR Doc. 92-20974 Filed 8-31-92; 8:45 am]

BILLING CODE 7590-01-M

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50-387 and 50-388]

Pennsylvania Power and Light Co., Allegheny Electric Cooperative, Inc.; Consideration of Issuance of Amendments to Facility Operating License, Proposed No Significant Hazards Consideration Determination, and Opportunity for Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of amendments to Facility Operating License Nos. NPF-14 and NPF-22 issued to Pennsylvania Power and Light Company and Allegheny Electric Cooperative, Inc. (the licensees) for operation of the Susquehanna Steam Electric Station (SSES), Units 1 and 2, located in Salem Township, Pennsylvania.

The proposed amendments would make changes to the technical specifications to prevent inadvertent isolation of the Reactor Water Cleanup (RWCU) system due to high seasonal temperatures while still providing timely leak detection capability.

Before issuance of the proposed license amendment, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

No Significant Hazards Consideration

I. The proposed change does not involve a significant increase in the probability or

consequence of an accident previously evaluated.

The SSES FSAR does not analyze the size of the small leak on which the temperature setpoints are based. Other accidents which result in coolant leakage outside containment are analyzed in FSAR Sections 15.6.2 (Instrument Line Break) and 15.6.4 (Steam System Piping Break Outside Containment). Both of these are assumed accidents, with no causes identified. The analysis in Section 15.6.4 is the enveloping evaluation for pipe breaks outside containment. The proposed 25 gpm leakage rate basis is well below the leakage corresponding to a catastrophic pipe failure for the applicable system piping and does not significantly increase the risk of a break.

The radiological consequences of a coolant leak outside primary containment was analyzed. The analysis concludes that there is no impact on the 10 CFR Part 100 offsite dose limits or on the 10 CFR Part 50, appendix A, GDC 19 control room dose limits.

Additionally, the temperature switches and isolation valves are redundant. Failure of a single switch to detect a leak does not preclude detection and where appropriate, isolation by the other switch and valve. The reliability of the temperature switches is not affected by the setpoint. The other methods of leak detection provide backup for the temperature instruments.

II. The proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

The proposed technical specification changes does not affect any systems other than leak detection and does not affect the ability to detect and isolate leakage. Although a 25 gpm leak is not specifically analyzed in the FSAR, it is bounded by the analysis in Chapter 15.6.4. The proposed change does not, therefore, create the possibility of an accident or malfunction of a different type than any evaluated previously in the FSAR.

III. The proposed change does not involve a significant reduction in a margin of safety.

The temperature switches and setpoints are listed in Technical Specification Section 3.3.2, "Isolation Actuation Instrumentation," but the Technical Specification basis does not discuss setpoint basis with respect to leakage rate or process conditions. The bases does, however, state "the set points . . . are established at a level away from the normal operating range to prevent inadvertent actuation of the system involved." Temperature measurement is not discussed in the basis for Technical Specification 3.4.3, "Reactor Coolant System Leakage."

The proposed technical specification change satisfies the bases for Section 3.3.2 by defining that the setpoints margin above maximum design temperatures, but does not reduce any margin of safety defined for any Technical Specification.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

The Commission is seeking public comments on this proposed determination. Any comments received within thirty (30) days after the date of publication of this notice will be considered in making any final determination. The Commission will not normally make a final determination unless it receives a request for a hearing.

Written comments may be submitted by mail to the Rules and Directives Review Branch, Division of Freedom of Information and Publications Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and should cite the publication date and page number of this *Federal Register* notice. Written comments may also be delivered to room P-223, Phillips Building, 7920 Norfolk Avenue, Bethesda, Maryland, from 7:30 a.m. to 4:15 p.m. Federal workdays. Copies of written comments received may be examined at the NRC Public Document Room, the Gelman Building, 2120 L Street NW., Washington, DC 20555. The filing of requests for hearing and petitions for leave to intervene is discussed below.

By October 1, 1992, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR part 2. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555 and at the local public document room located at Osterhout Free Library, Reference Department, 71 South Franklin Street, Wilkes-Barre, Pennsylvania 18701. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board, will rule on the request and/or petition; and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and

how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to

present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish in the *Federal Register* a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Services Branch, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555, by the above date. Where petitions are filed during the last ten (10) days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at 1-(800) 325-6000 (in Missouri 1-(800) 342-6700). The Western Union operator should be given Datagram Identification Number N1023 and the following message addressed to Charles L. Miller, Director, Project Directorate I-2, Division of Reactor Projects—I/II: petitioner's name and telephone number, date petition was mailed, plant name, and publication date and page number of this *Federal Register* notice. A copy of the petition

should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to Shaw, Pittman, Potts and Trowbridge, 2300 N Street NW., Washington, DC 20037, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)-(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated January 9, 1991, and its supplements dated August 19, 1991, June 22, 1992 and August 3, 1992, which are available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC 20555 and at the local public document room located at Osterhout Free Library, Reference Department, 71 South Franklin Street, Wilkes-Barre, Pennsylvania 18701.

Dated at Rockville, Maryland, this 26th day of August 1992.

For the Nuclear Regulatory Commission.

Richard J. Clark,

Acting Project Director, Project Directorate I-2, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 92-20977 Filed 8-31-92; 8:45 am]

BILLING CODE 7590-01-M

NUCLEAR WASTE TECHNICAL REVIEW BOARD

Meeting of Full Board in Las Vegas, Nevada—October 14-16, 1992

Pursuant to the Nuclear Waste Technical Review Board's (the Board) authority under section 5051 of the Nuclear Waste Policy Amendments Act (NWPAA) of 1987 (Public Law 100-203), the Board will hold its fall meeting October 14-16, 1992, in Las Vegas, Nevada. The meeting will address two issues: the source term and the fiscal year 1993 budget for the Yucca Mountain Site Characterization Project Office. The meeting, which is open to the public, will be held at the Plaza-Suite Hotel, 4255 South Paradise, Las Vegas, Nevada, 89109; telephone (702) 369-4400.

The Board has invited representatives from the DOE's Office of Civilian Radioactive Waste Management and its contractors to make presentations on the source term, which can be defined

as the kinds and amounts of radionuclides that could be released from the waste package and its immediate repository surroundings and, thereby, be available for transport under various release scenarios. Three areas will be addressed. First, how could factors such as fuel characteristics, fuel oxidation, glass dissolution rates, and cladding failure affect the source term? Second, how could geochemical reactions at the potential site affect the source term? For example, factors affecting the potential release of ^{14}C and the effects of backfill materials on solubility and sorption will be discussed. Finally, how has the source term been treated in previous performance assessment calculations, and how might it be treated in future performance assessments?

Carl Gertz, director of the Yucca Mountain Site Characterization Project Office, also will make a presentation on that office's fiscal year 1993 budget and its implications for the 2001 license application target date.

The Nuclear Waste Technical Review Board was created by Congress in the Nuclear Waste Policy Amendments Act of 1987 (NWPAA) to evaluate the technical and scientific validity of activities undertaken by the DOE in its program to manage the disposal of the nation's spent fuel. In that same legislation, Congress directed the DOE to characterize a site at Yucca Mountain, Nevada, for its suitability as a potential location for a permanent repository for disposal of that spent nuclear fuel.

Transcripts of the meeting will be available on a library-loan basis from Ms. Victoria Reich, Board Librarian, beginning November 30, 1992. For further information, contact Paula N. Alford, Director, External Affairs, 1100 Wilson Boulevard, suite 910, Arlington, Virginia 22209; (703) 235-4473.

Dated: August 27, 1992.

William D. Barnard,

Executive Director, Nuclear Waste Technical Review Board.

[FR Doc. 92-21022 Filed 8-31-92; 8:45 am]

BILLING CODE 6820-AM-M

RESOLUTION TRUST CORPORATION

List of Institutions in Conservatorship and Receivership

AGENCY: Resolution Trust Corporation.

ACTION: Notice of Conservatorships and Receiverships.

SUMMARY: The Resolution Trust Corporation (Corporation or RTC) on

May 7, 1992 [57 FR 19651] published for comment an Interim Statement of Policy on Foreclosure Consent and Redemption Rights. As part of that Policy, the RTC agreed to publish a list of all institutions for which the RTC has been appointed receiver or conservator. In addition, the RTC agreed to periodically publish a notice indicating new institutions for which the RTC has been appointed

receiver since the date of the previous notice.

DATES: This publication includes all institutions which passed through receivership between August 9, 1989 and June 30, 1992.

FOR FURTHER INFORMATION CONTACT: Prem Dhawan, Asset Specialist, Office of Asset Disposition, (214) 443-4816, or Joseph S. Schantz, Asset Specialist,

Asset Management and Sales Division, (202) 416-7302. (These are not toll-free numbers).

SUPPLEMENTARY INFORMATION: Listed below are institutions controlled by the RTC which have been passed through the receivership process between August 9, 1989 and June 30, 1992. This list is sorted alphabetically first by state, then city, and finally by name of institution.

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8301	06020	First Federal Bank of Alaska SB	Anchorage	AK		3/02/89	1/12/90
8302	07329	Home Savings Bank	Anchorage	AK	8/31/89	3/02/89	1/12/90
	08647	Home Savings Bank, FSB	Anchorage	AK			
8233	02937	First FS&LA	Andalusia	AL	12/28/90	12/28/90	9/27/91
	09041	First FS&LA of Andalusia, FA	Andalusia	AL			
8303	04939	City FS&LA	Birmingham	AL		3/30/89	9/14/90
8304	04439	Guaranty FS&LA	Birmingham	AL		2/17/89	5/04/90
7868	02439	Jefferson FS&LA	Birmingham	AL	3/08/91	3/08/91	3/13/92
	09089	Jefferson FS&LA, FA	Birmingham	AL			
8307	06772	First Savings Bank of Alabama, FA	Hamilton	AL		3/09/89	12/15/89
8230	02747	Altus Bank, A FSB	Mobile	AL	5/17/91	5/17/91	
	09231	Altus Federal Savings Bank	Mobile	AL			
8306	08439	Phenix FS&LA, FA	Phenix City	AL		3/09/89	5/18/90
8305	00840	Baldwin County FSB	Robertsdale	AL		3/30/89	8/10/90
7870	04793	Tuskegee FS&LA	Tuskegee	AL	11/30/90	11/30/90	10/11/91
	09017	Tuskegee S&LA, FA	Tuskegee	AL			
8310	07255	Independence FS&LA	Batesville	AR		2/17/89	9/07/90
8312	05724	First FS&LA	Fayetteville	AR		3/02/89	11/02/90
8692	00668	First America Federal Savings Bank	Fort Smith	AR	5/25/90	5/25/90	12/07/90
	08838	First American SB, FSB	Fort Smith	AR			
8311	03115	Landmark Savings Bank, FSB	Hot Springs	AR		3/02/89	6/22/90
7867	02362	United FS&LA	Jonesboro	AR	6/28/91	6/28/91	3/13/92
	09290	United FS&LA, FA	Jonesboro	AR			
8833	07899	Arkansas Federal Savings Bank	Little Rock	AR	12/21/90	12/21/90	9/06/91
	09040	Arkansas Federal Savings Bank, FA	Little Rock	AR			
8308	02354	First Federal of Arkansas, FA	Little Rock	AR	8/31/89	2/10/89	7/26/91
	08643	First Savings of Arkansas, FA	Little Rock	AR			
8309	03429	Savers FS&LA	Little Rock	AR	10/05/89	2/10/89	9/20/91
	08673	Savers Savings Association, FSA	Little Rock	AR			
8315	05836	First FS&LA	Malvern	AR		3/02/89	8/25/89
8314	06401	First State Savings Bank FSB	Mountain Home	AR		3/02/89	10/26/90
8316	07625	Home FS&LA	Mountain Home	AR		3/02/89	8/25/89
8313	07601	Madison Guaranty S&LA	McCrary	AR		3/02/89	11/30/90
8317	07306	Commonwealth S&LA	Osceola	AR		3/02/89	12/07/90
7885	03495	First FS&LA	Paragould	AR	11/30/90	11/30/90	9/13/91
	09019	First Savings Association, FA	Paragould	AR			
8825	07700	Grand Prairie S&LA	Stuttgart	AR	1/26/90	1/26/90	11/09/90
	08743	Grand Prairie FS&LA	Stuttgart	AR			
8897	00137	Texarkana FS&LA	Taxarkana	AR	12/07/90	12/07/90	8/30/91
	09023	Texarkana FS&LA, FA	Taxarkana	AR			
8318	07617	Unipoint Federal Savings Bank	Trumann	AR		3/02/89	6/22/90
8622	07599	Capital S&LA	Wes Helena	AR	7/27/89	7/27/89	6/29/90
	08615	Capital FS&LA	Little Rock	AR			
8806	06877	Merabank, a Federal Savings Bank	Phoenix	AZ	1/31/90	1/31/90	9/28/90
	08764	Merabank FSB	Phoenix	AZ			
8840	08065	Sentinel S&LA	Phoenix	AZ	2/02/90	2/02/90	6/15/90
	08763	Sentinel FS&LA	Phoenix	AZ			
8522	05628	Southwest S&LA	Phoenix	AZ	9/14/89	2/17/89	7/19/91
	08636	Southwest S&LA, FA	Phoenix	AZ			
8583	07710	Sun State S&LA	Phoenix	AZ	6/14/89	6/14/89	11/30/90
	08590	Sun State S&LA, FSA	Phoenix	AZ			
8603	01920	Western S&LA	Phoenix	AZ	6/14/89	6/14/89	5/31/90
	08579	Western S&LA, FA	Phoenix	AZ			
8319	06875	Security S&LA	Scottsdale	AZ		2/17/89	3/15/91
8524	08493	Universal S&LA, A FS&LA	Scottsdale	AZ		2/17/89	1/26/90
7905	08048	First American Savings, Inc.	Tucson	AZ	8/16/91	8/16/91	4/24/92
	09388	First American Federal Savings Bank	Tucson	AZ			
8858	05762	PIMA S&LA	Tucson	AZ	5/25/90	3/02/90	2/15/91
	08839	PIMA FS&LA	Tucson	AZ			
7900	06962	Progressive S&LA	Alhambra	CA	5/24/91	5/24/91	3/13/92
	09232	Progressive Savings Bank, FSB	Pasadena	CA			
8606	00924	First FS&LA	Bakersfield	CA		6/29/89	4/27/90

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8564	07898	The Guardian FS&LA	Bakersfield	CA		6/29/89	4/27/90
7790	06325	Columbia S&LA	Beverly Hills	CA	3/22/91	1/25/91	9/13/91
	09104	Columbia S&LA, FA	Beverly Hills	CA			
8557	07277	Gibraltar Savings	Beverly Hills	CA	10/31/89	3/31/89	6/29/90
	08687	Gibraltar Savings, FA	Simi Valley	CA			
8604	08253	Sierra FS&LA	Beverly Hills	CA	7/20/89	7/20/89	5/04/90
	08613	Sierra S&LA, FA	Beverly Hills	CA			
7881	07868	Unity S&LA	Beverly Hills	CA	2/08/91	2/08/91	8/02/91
	09054	Unity Savings & Loan Association, FA	Beverly Hills	CA			
8805	06811	Enterprise S&LA	Compton	CA		5/31/91	
8320	01841	Pacific Savings Bank	Costa Mesa	CA		2/07/89	10/13/89
7906	08224	Gold River SB	Fair Oaks	CA			9/27/91
8846	08164	Financial S&LA	Fresno	CA	1/11/90	1/11/90	6/01/90
	08715	Financial FS&LA	Fresno	CA			
8625	06207	Security FS&LA	Garden Grove	CA	11/16/89	11/16/89	5/04/90
	08708	Security FSA	Garden Grove	CA			
8859	07663	Westport Savings Bank	Hanford	CA	3/09/90	3/09/90	8/17/90
	08779	Westport Federal Savings Bank	Hanford	CA			
8553	07901	Cabrillo Savings Bank	Hayward	CA	8/31/89	4/06/89	5/11/90
	08631	Cabrillo Federal Savings Bank	Hayward	CA			
7887	08154	Beach Savings Bank	Huntington Beach	CA	1/18/91	1/18/91	7/19/91
	09046	Beach Savings Bank, FSB	Fountain Valley	CA			
8822	07608	Charter Savings Bank	Huntington Beach	CA	6/15/90	6/15/90	12/07/90
	08881	Charter Savings Bank, FSB	Newport Beach	CA			
8629	07846	Huntington S&LA	Huntington Beach	CA	2/09/90	2/09/90	6/22/90
	08751	Huntington FS&LA	Huntington Beach	CA			
8801	06649	Mercury S&LA	Huntington Beach	CA	5/25/90	2/23/90	9/21/90
	08833	Mercury FS&LA	Huntington Beach	CA			
8837	07970	Liberty S&LA	Huntington Park	CA	11/16/90	11/16/90	6/07/91
	08978	Liberty Federal Savings Bank	Montebello	CA			
8828	07754	Heartland S&LA	La Mesa	CA			9/06/91
7828	07961	Guardian S&LA	Long Beach	CA	12/06/91	6/21/91	
	09569	Guardian Federal Savings Association	Long Beach	CA			
8565	08306	American Interstate Savings, A FS&L	Los Angeles	CA	7/20/89	7/20/89	5/04/90
	08595	American Interstate SA, FA	Los Angeles	CA			
8656	07887	Brookside S&LA	Los Angeles	CA	11/30/89	11/30/89	11/16/90
	08705	Brookside FS&LA	Los Angeles	CA			
8867	07974	First Network Savings Bank	Los Angeles	CA	4/20/90	4/20/90	9/14/90
	08808	First Network SFB	Los Angeles	CA			
8324	07353	Founders S&LA	Los Angeles	CA	9/07/89	4/06/89	1/18/91
	08634	Founders FS&LA	Los Angeles	CA			
8560	03805	Lincoln S&LA	Los Angeles	CA	8/03/89	4/14/89	3/08/91
	08619	Lincoln S&LA, FA	Los Angeles	CA			
8561	05073	Southwest S&LA	Los Angeles	CA	10/05/89	4/27/89	11/16/90
	08678	Southwest FS&LA	Los Angeles	CA			
8321	07611	Westwood S&LA	Los Angeles	CA		2/17/89	8/24/90
8674	07979	Wilshire S&LA	Los Angeles	CA	1/11/90	1/11/89	6/22/90
	08716	Wilshire S&LA	Los Angeles	CA			
7820	07888	Malibu Savings Bank	Malibu	CA	1/11/91	1/11/91	7/19/91
	09045	Malibu Savings Bank, FSB	Malibu	CA			
8332	07886	Royal Oak S&LA	Manteca	CA		4/06/89	5/11/90
7630	07991	Executive S&LA	Marina Del Rey	CA	4/26/91	4/26/91	2/28/92
	09166	Executive Savings Bank, FSB	Marina Del Rey	CA			
7711	01314	Far West S&LA	Newport Beach	CA	2/15/91	1/11/91	3/20/92
	09077	Farwest S&LA, FA	Irvine	CA			
7966	08277	First Newport, FSB (University, FSB)	Newport Beach	CA	6/19/92	6/19/92	
	08277	First Newport Federal Savings Bank	Newport Beach	CA			
7948	08004	Advanced S&LA	Northridge	CA	1/24/92	1/24/92	
	09696	Advanced Federal Savings Bank	Northridge	CA			
8331	08352	Unified Savings, A FS&LA	Northridge	CA		4/06/89	9/22/89
8334	07347	City FS&LA	Oakland	CA		4/06/89	5/18/90
8323	08445	First California Savings, FSA	Orange	CA		4/06/89	9/22/89
8328	07781	Arrowhead Pacific Savings Bank	San Bernardino	CA	8/24/89	4/06/89	5/04/90
	08638	Arrowhead Pacific FSB	San Bernardino	CA			
7932	06991	San Clemente Savings Bank	San Clemente	CA	6/12/92		
	06991	San Clemente FSB	San Clemente	CA			
7705	00789	Great American First Savings Bank	San Diego	CA	10/25/91	8/09/91	
	09498	Great American FSA	San Diego	CA			
8206	01761	Imperial Savings Association	San Diego	CA	6/22/90	2/23/90	4/19/91
	08882	Imperial FSA	San Diego	CA			
8881	07959	Rancho Bernardo Savings Bank	San Diego	CA	10/26/90	10/26/90	6/07/91
	08962	Rancho Bernardo Federal Savings Bank	San Diego	CA			
7840	08117	Atlantic Financial Savings Bank, FSB	San Francisco	CA	7/26/91	7/26/91	4/10/92
	09384	Atlantic Financial FSB	San Francisco	CA			
8326	07799	Gateway Savings Bank	San Francisco	CA	4/06/89	6/08/90	
	08640	Gateway Federal Savings Bank	San Francisco	CA			
8830	07849	Pacific Coast S&LA of America	San Francisco	CA	4/27/90	3/16/90	7/12/91

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8815	08836	Pacific Coast FSA of America	San Francisco	CA			
	07325	Time S&LA	San Francisco	CA	6/01/90	6/01/90	5/17/91
	08834	Time FS&LA	San Francisco	CA			
8618	07928	Saratoga S&LA	San Jose	CA	5/24/90	11/09/89	6/01/90
	08828	Saratoga FS&LA	San Jose	CA			
8841	07483	Pan American SB	San Mateo	CA		7/21/91	
8330	06388	Perpetual Savings Association, a FS&LA	Santa Ana	CA		4/06/89	6/25/89
7818	07847	County Bank, SSB	Santa Barbara	CA	3/27/91	3/27/91	3/27/92
	09099	County Bank, FSB	Santa Barbara	CA			
8213	02079	Santa Barbara S&LA	Santa Barbara	CA	5/11/90	4/27/90	8/09/91
	08850	Santa Barbara FS&LA	Santa Barbara	CA			
7704	00437	Santa Paula S&LA	Santa Paula	CA			9/27/91
8824	07688	Peninsula S&LA	South San Francisco	CA	05/04/90	05/04/90	6/22/90
	08829	Peninsula FSA	South San Francisco	CA			
0827	07835	Washington S&LA	Stockton	CA		04/06/89	5/11/90
8800	06645	Constitution FS&LA	Tustin	CA	4/12/90	4/12/90	6/29/90
	08796	Constitution FSA	Monterey Park	CA			
8526	07438	Independence S&LA	Vallejo	CA		4/06/89	10/20/89
7810	07443	Valley FS&LA	Van Nuys	CA			4/10/92
8527	07985	City S&LA	Westlake Villa	CA		4/06/89	8/25/89
7930	07897	Delta Savings Bank	Westminster	CA	5/08/92	11/08/91	
	09976	Delta FSB	Westminster	CA			
8562	01737	Westco Savings Bank, FSB	Wilmington	CA		4/27/89	4/27/90
8823	07634	Investment S&LA	Woodland Mills	CA	1/11/90	1/11/90	8/24/90
	08735	Investment FS&LA	Woodland Mills	CA			
8855	07853	Western Empire S&LA	Yorba Linda	CA	2/16/90	2/16/90	8/31/90
	08750	Western Empire FS&LA	Yorba Linda	CA			
8660	07308	Aspen S&LA	Aspen	CO	11/09/89	11/09/89	8/08/90
	08694	Aspen Savings Bank, FSB	Aspen	CO			
8207	01777	Capitol FS&LA of Denver	Aurora	CO	6/15/90	5/04/90	7/12/91
	08869	Capitol FS&LA	Aurora	CO			
8525	02864	American FS&LA of Colorado	Colorado Springs	CO	9/28/89	4/06/89	5/18/90
	08670	American Savings of Colorado, A FS&LA	Colorado Springs	CO			
8532	02424	First FS&LA of Colorado Springs	Colorado Springs	CO		3/09/89	6/29/90
8529	00948	Otero S&LA	Colorado Springs	CO		3/09/89	5/25/90
8878	08476	Great West SB, FSB	Craig	CO	5/11/90	5/11/90	8/16/91
	08824	Great West, A Federal Savings Bank	Craig	CO			
8340	05776	Equity Federal Savings Bank	Denver	CO		4/06/89	9/14/90
8530	07623	Colorado S&LA	Englewood	CO		3/09/89	2/09/90
8335	01421	Mesa FS&LA of Colorado	Grand Junction	CO		3/09/89	2/02/90
8337	02337	Modern FS&LA	Grand Junction	CO		3/09/89	1/26/90
8336	01541	Valley FS&LA of Grand Junction	Grand Junction	CO	8/24/89	3/09/89	2/02/90
	08642	Valley FS&LA	Grand Junction	CO			
8872	05134	Heritage S&LA	Lamar	CO	4/20/90	4/20/90	8/23/91
	08823	Heritage Federal Savings Association	Lamar	CO			
8844	08151	First America Savings Bank, FSB	Longmont	CO	3/16/90	3/16/90	9/13/91
	08802	First America Federal Savings Bank	Longmont	CO			
8528	03651	Sun S&LA	Parker	CO		3/09/89	7/20/90
8338	03029	Alpine FS&LA	Steamboat Springs	CO	8/24/89	3/09/89	6/22/90
	08641	Alpine Savings, A FS&LA	Steamboat Springs	CO			
8567	08354	Colorado FSB	Sterling	CO	9/28/89	9/28/89	6/29/90
	08669	Colorado Savings Bank, FSB	Sterling	CO			
8339	07782	Rocky Mountain S&LA	Woodland Park	CO		3/09/89	6/22/90
8628	07373	Community FS&LA	Bridgeport	CT	12/07/89	12/07/89	9/14/90
	08707	Community Federal Savings Association	Bridgeport	CT			
7856	00350	Danbury S&LA Inc	Danbury	CT	7/12/91	7/12/91	3/13/92
	09321	Danbury FS&LA	Danbury	CT			
7879	07179	Connecticut S&LA	Hartford	CT	1/11/91	1/11/91	2/07/92
	09044	Connecticut Federal Savings and Loan	Hartford	CT			
7843	08195	Financial Federal Savings Bank	Hartford	CT	8/17/90	8/17/90	6/19/91
	08906	Financial Savings of Hartford	Hartford	CT			
7907	03633	New London FS&LA	New London	CT	6/19/92	6/19/92	
	03633	Coastal SB, FSB	New London	CT			
8889	08009	Charter FS&LA	Stamford	CT	6/29/90	6/29/90	6/21/91
	08868	Charter FSA	Stamford	CT			
8849	07792	Security S&LA	Waterbury	CT	4/12/91	4/12/91	3/20/92
	09157	Security FS&LA	Waterbury	CT			
8341	06927	Columbia Federal Savings Bank	Westport	CT		2/17/89	4/12/90

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Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8348	08401	Southern Floridabanc FS&LA	Boca Raton	FL	2/17/89	10/06/89	
7817	08263	Coral Coast Savings Bank, FSB	Boynton Beach	FL	8/02/91	8/02/91	
	09385	Coral Coast Federal Savings Bank	Boynton Beach	FL			
8839	08053	Enterprise FS&LA	Clearwater	FL	4/20/90	4/20/90	9/07/90
	08819	Enterprise FS, FSA	Clearwater	FL			
8896	07699	Life Savings Bank	Clearwater	FL	10/11/91	10/11/91	
	09470	Life Federal Savings Bank	Clearwater	FL			
8288	05942	Pioneer Savings Bank	Clearwater	FL	3/09/90	2/02/90	3/01/91
	08801	Pioneer Federal Savings Bank	Clearwater	FL			
7783	06002	Professional Savings Bank	Coral Gables	FL	7/27/90	7/27/90	3/13/92
	08917	Professional Federal Savings Bank	Coral Gables	FL			
8850	08381	Coral S&LA	Coral Springs	FL	1/25/91	1/25/91	6/28/91
	09049	Coral S&LA, FA	Coral Springs	FL			
8245	03121	Security First FS&LA	Daytona Beach	FL			4/10/92
8843	08133	Investors of Florida Savings Bank	Deerfield Beach	FL	6/01/90	6/01/90	6/07/91
	08821	Investors Federal Savings Bank	Deerfield Beach	FL			
8347	08548	Financial Security S & LA	Delray Beach	FL		3/16/89	5/25/90
8808	06996	First Citizens FS&LA	Fort Pierce	FL	3/08/91	3/08/91	9/20/91
	09090	First Citizens S&LA, FA	Fort Pierce	FL			
8607	08331	New Metropolitan FS&LA	Hialeah	FL	7/19/91	7/19/91	2/28/92
	09322	New Metropolitan Federal Savings Bank	Hialeah	FL			
7734	02767	Hollywood FS&LA	Hollywood	FL	2/22/91	2/22/91	
	09079	Hollywood Federal Savings Bank	Hollywood	FL			
7860	08531	Citizens Federal Savings Bank	Jacksonville	FL	10/16/91	10/16/91	
	09473	Citizens Federal Savings Association	Jacksonville	FL			
8653	05731	Duval FS&LA	Jacksonville	FL	1/18/90	1/18/90	8/16/91
	08754	Duval Federal Savings Association	Jacksonville	FL			
7964	05108	Jacksonville Federal Savings Bank	Jacksonville	FL	6/26/92	6/26/92	
	05108	Jacksonville FSB	Jacksonville	FL			
8345	05553	First FS&LA of the Florida Keys	Key West	FL		3/16/89	4/27/90
8344	06596	First FS&LA	Largo	FL		2/17/89	6/08/90
8617	07823	Commonwealth S&LA	Margate	FL	7/20/89	7/20/89	3/08/91
	08628	Commonwealth FS&LA	Margate	FL			
7767	05078	United Savings of America, FA	Melbourne	FL			2/07/92
7722	02143	Amerifirst Bank, A FSB	Miami	FL	3/15/91	3/15/91	3/20/92
	09094	Amerifirst Federal Savings Bank	Miami	FL			
8353	07731	Brickellbanc Savings Association	Miami	FL		3/16/89	6/08/90
8229	02745	Centrust Bank, A State Savings Bank	Miami	FL	3/09/90	2/02/90	6/29/90
	08800	Centrust FSB	Miami	FL			
7782	05976	Flagler FS&LA	Miami	FL			3/27/92
8629	07763	General Bank, A Federal Savings Bank	Miami	FL	11/16/89	11/16/89	1/11/91
	08695	General Federal Savings Bank	Miami	FL			
8531	07769	Lincoln S&LA	Miami	FL	10/05/89	3/16/89	6/08/90
	08674	Lincoln FS&LA	Miami	FL			
8346	07363	Miami Savings Bank	Miami	FL		3/16/89	8/7/90
8350	08409	Liberty FS&LA	New Port Richey	FL		3/16/89	8/10/89
7880	07805	International S&LA	North Miami Beach	FL	10/12/90	10/12/90	7/05/91
	08971	International Federal S&LA	North Miami Beach	FL			
8886	07796	American Pioneer Savings Bank	Orlando	FL	6/29/90	5/25/90	9/20/91
	08867	American Pioneer Federal Saving Bank	Orlando	FL			
7725	02314	The First, FA	Orlando	FL			10/11/91
7838	08060	Hansen Savings Bank	Palm Beach Gardens	FL	1/10/92	1/10/92	
	09619	Hansen Federal Savings Bank	Palm Beach Gardens	FL			
7854	08365	Sovereign Savings Bank	Palm Harbor	FL	3/15/91	3/15/91	9/13/91
	09092	Sovereign Savings Bank, FSB	Palm Harbor	FL			
7875	05587	Security FSB of Florida	Panama City	FL	1/31/92	1/31/92	
	09697	Security Federal Savings Association	Panama City	FL			
7834	08036	Citizens & Builders FSB	Pensacola	FL	7/27/90	7/27/90	7/12/91
	08914	Citizens & Builders FS, FSB	Pensacola	FL			
7837	08056	Gold Coast Savings Bank	Plantation	FL	10/19/90	10/19/90	8/23/91
	08970	Gold Coast Federal Savings Bank	Plantation	FL			
7744	03421	First FS&LA of Seminole County	Sanford	FL	4/05/91	4/05/91	4/03/92
	09121	First FS&LA of Seminole County, FA	Sanford	FL			
8211	01943	Florida Federal Savings Bank	St. Petersburg	FL	11/09/90	11/09/90	8/02/91
	08968	Florida Federal Savings, FSB	St. Petersburg	FL			
7793	06482	Goldome SA	St. Petersburg	FL	5/31/91	5/31/91	
	09235	Goldome Federal Savings Bank	St. Petersburg	FL			
8885	08144	Great Life Savings Association	Sunrise	FL	6/01/90	6/01/90	6/21/91
	08845	Great Life FSA	Sunrise	FL			
7832	09015	Ambassador S&LA	Tamarac	FL	8/24/90	8/24/90	6/21/91
	08916	Ambassador FS&LA	Tamarac	FL			
8356	07163	Community FS&LA	Tampa	FL		3/16/89	9/07/90
8342	08427	Freedom S&LA A FS&LA	Tampa	FL		2/07/89	10/13/89
8351	07829	First Venice S&LA	Venice	FL		3/16/89	6/01/90
7909	08281	Bay Savings Bank	West Palm Beach	FL	9/06/91	9/06/91	
	09419	Bay Federal Savings Bank	West Palm Beach	FL			

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Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8533	07923	Royal Palm Savings Bank	West Palm Beach	FL	7/19/89	3/16/89	6/08/90
	08602	Royal Palm FS&LA	West Palm Beach	FL			
8851	08497	Haven FS&LA	Winter Haven	FL	3/02/90	3/02/90	12/07/90
	08783	Haven S&LA, FA	Winter Haven	FL			
8568	05384	First FS&LA	Americus	GA	6/22/89	6/22/89	6/22/90
	08582	First Savings of Americus, A FS&LA	Americus	GA			
8827	06643	First Federal Savings Bank	Ashburn	GA	4/05/91	4/05/91	4/03/92
	09122	First Federal Savings Bank, FSB	Ashburn	GA			
8357	00141	First FS&LA	Atlanta	GA		3/09/89	5/25/90
8215	02322	Fulton Federal Savings Bank	Atlanta	GA	2/01/91	1/04/91	7/26/91
	09052	Fulton Federal Savings Association	Atlanta	GA			
8569	00552	Habersham FSB	Atlanta	GA	6/22/89	6/22/89	9/21/89
	08592	Habersham FS&LA	Cornelia	GA			
7796	06529	First FS&LA	Dallas	GA	2/22/91	2/22/91	9/27/91
	09080	First Federal Savings, FSB	Dallas	GA			
7852	08414	Cobb Federal Savings Bank	Marietta	GA	11/08/91	11/08/91	
	09500	Cobb Federal Savings Association	Marietta	GA			
8688	00490	Moultrie Federal Savings Bank	Moultrie	GA	6/15/90	6/15/90	1/04/91
	08874	Moultrie Savings Bank, FSB	Moultrie	GA			
8570	03572	Great Southern FSB	Savannah	GA	6/22/89	6/22/89	6/22/90
	08586	Great Southern FS&LA	Savannah	GA			
7877	06650	United FS&LA	Smyrna	GA	5/31/91	5/31/91	3/27/92
	09237	United Federal Savings Bank	Smyrna	GA			
8359	06090	First FS&LA	Summerville	GA		3/09/89	6/22/90
7781	06146	The Federal Savings Bank	Swainsboro	GA	3/22/91	3/22/91	3/27/92
	09102	The Federal Savings Bank, FSB	Atlanta	GA			
8299	06582	First FS&LA	Warner Robins	GA	4/12/90	4/12/90	8/17/90
	08825	First FSA	Warner Robins	GA			
7819	07852	Guaranty Federal Savings Bank	Warner Robins	GA	5/10/91	5/10/91	3/13/92
	09229	Guaranty Federal Savings Association	Warner Robins	GA			
7749	03709	Home FS&LA	Algona	IA	4/26/91	4/26/91	1/31/92
	09165	Home FS&LA, FA	Algona	IA			
8571	04234	Banc Iowa Savings Bank	Cedar Rapids	IA	10/16/89	10/16/89	8/10/90
	08680	Banc Iowa Federal Savings Bank	Cedar Rapids	IA			
8271	04604	Firstcentral Bank, a FSB	Chariton	IA	1/04/90	1/04/90	9/07/90
	08742	Firstcentral Federal Savings Bank	Chariton	IA			
8360	05488	Sioux Valley S&LA	Cherokee	IA		4/06/89	8/18/89
8223	02557	First FS&LA of Creston	Creston	IA	5/10/91	5/10/91	11/01/91
	09227	First FS&LA of Creston, FA	Creston	IA			
8262	03965	American FS&LA of Iowa	Des Moines	IA	2/09/90	2/09/90	2/08/91
	08749	American FSA of Iowa	Des Moines	IA	2/09/90	2/09/90	2/08/91
8247	03228	United Federal Savings Bank of Iowa	Des Moines	IA	3/22/91	3/22/91	
	09103	United FSA of Iowa	Des Moines	IA			
8534	03406	First FS&LA of Estherville & Emmetsburg	Estherville	IA		4/06/89	6/15/90
8861	07162	Sun Savings Bank	Fort Dodge	IA	3/16/90	3/16/90	6/28/90
	08788	Sun FS&LA	Fort Dodge	IA			
7738	02896	Home FS&LA of Harlan	Harlan	IA			9/27/91
7910	01319	Peoples S&LA	Ottumwa	IA	11/22/91	11/22/91	3/30/92
	09568	Peoples FSA	Ottumwa	IA			
7858	08482	Statesman Bank for Savings, FSB	Waterloo	IA	7/27/90	7/27/90	3/01/91
	08890	Statesman Federal Savings Bank	Des Moines	IA			
7771	05217	Germaniabank, a FSB	Alton	IL		6/22/90	7/26/91
8281	05469	Arlington Heights FS&LA	Arlington Heights	IL	12/07/89	12/07/89	9/28/90
	08710	Arlington Heights SA, FA	Arlington Heights	IL			
8682	00241	Frontier Financial	Belleville	IL	1/18/90	1/18/90	11/29/90
	08728	Frontier Federal Savings Bank	Belleville	IL			
8365	00168	Midwest Home FSB	Belleville	IL		3/16/89	11/30/90
8695	00982	Olympic Federal S&LA	Berwyn	IL	12/14/90	12/14/90	3/27/92
	09028	Olympic Federal Savings Association	Berwyn	IL			
8370	02193	Home FS&LA of Centralia	Centralia	IL		3/16/89	5/08/90
8368	00104	American Security FS&LA	Chicago	IL		3/16/89	6/19/90
7731	01774	Capitol Federal Bank for Savings	Chicago	IL			5/10/91
7772	05242	Century Federal Savings Bank	Chicago	IL	5/03/91	5/03/91	1/31/92
	09170	Century Federal Savings Bank, FSB	Chicago	IL			
7743	03418	Enterprise Savings Bank, FA	Chicago	IL			12/27/90
8691	00636	United Savings of America	Chicago	IL			9/27/91
7931	01614	Western S&LA	Chicago	IL	11/22/91	11/22/91	3/20/92
	09587	Western FS&LA	Glenview	IL			
8369	03416	Chillicothe FS&LA	Chillicothe	IL		3/16/89	8/24/90
8864	02441	Fidelity S&LA of Danville	Danville	IL	2/16/90	2/16/90	8/22/90
	08758	Fidelity Savings Bank, FSB	Danville	IL			
8554	01186	First Federal Savings Bank	East Alton	IL		4/06/89	5/04/90
8294	06338	Community Savings Bank	East Moline	IL	2/23/90	2/23/90	11/02/90
	08784	Community Federal Savings Bank	East Moline	IL			
8649	00345	Fidelity FS&LA	Galesburg	IL	11/09/89	11/09/89	11/16/90
	08698	Fidelity Federal Savings Association	Galesburg	IL			
8364	00238	Madison County FS&LA	Granite City	IL		3/16/89	5/18/90

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8572	06743	Amerimac Savings Bank, FS	Hillsboro	IL		6/29/89	5/15/90
8626	05655	Heritage S&L	Jerseyville	IL	8/24/89	8/24/89	8/24/90
	08658	Heritage Savings Association, FA	Jerseyville	IL			
8363	06330	Home FS&LA of Joliet	Joliet	IL	9/07/89	3/16/89	11/09/90
	08654	Home Savings, a FS&LA	Joliet	IL			
8657	06102	Crest Savings	Kankakee	IL	11/09/89	11/09/89	9/14/90
	08697	Crest FS&LA	Kankakee	IL			
8361	03366	Concordia Federal Bank for Savings	Lansing	IL		2/17/89	5/29/90
7935	06239	Lemont SA	Lemont	IL	2/28/92	2/28/92	
	09701	Lemont Federal Savings Association	Lemont	IL			
8367	00072	Libertyville FS&LA	Libertyville	IL		4/06/89	4/27/90
8366	00354	Midwestern SA	Macomb	IL		3/16/89	6/22/90
7955	08213	Republic Savings Bank, FSB	Matteson	IL	6/05/92	6/05/92	
	09978	Republic FSB	Matteson	IL			
7753	04152	American S&LA	Mt Carmel	IL	8/10/90	8/10/90	6/07/91
	08912	American SA of Mt Carmel, FA	Mt Carmel	IL			
8297	06489	New Athens S&LA	New Athens	IL	3/02/90	3/02/90	11/16/90
	08803	New Athens FS&LA	New Athens	IL			
8852	03502	Clyde FS&LA	North Riverside	IL	2/02/90	2/02/90	5/31/91
	08775	Clyde FSA	North Riverside	IL			
8224	02605	Great American FS&LA	Oak Park	IL	5/25/90	2/16/90	9/21/90
	08822	Great American S&LA, FA	Oak Park	IL			
8373	08362	First Savings of America, a FS&LA	Orland Park	IL		3/16/89	8/10/89
8537	06798	Illinois Savings Bank, FA	Peoria	IL		3/16/89	8/17/90
8615	04203	Security S&LA, FA	Peoria	IL	8/17/89	8/17/89	8/17/90
	08644	Security FS&LA	Peoria	IL			
8220	02442	GEM City S&LA	Quincy	IL	1/18/90	1/18/90	9/07/90
	08719	GEM City FS&LA	Quincy	IL			
8620	03080	Black Hawk FS&LA	Rock Island	IL	8/17/89	8/17/89	6/29/90
	08633	Black Hawk S&LA, FA	Rock Island	IL			
8888	07626	Bank USA Savings Association	Silvis	IL		5/25/90	11/09/90
8536	06137	Skokie FS&LA	Skokie	IL	7/20/89	7/20/89	2/06/90
	06137	Skokie FS&LA, FA	Skokie	IL			
8621	00908	Citizens S&LA of Springfield	Springfield	IL	9/07/89	9/07/89	6/22/90
	08653	Citizens S&LA of Springfield FA	Springfield	IL			
8654	01006	St Charles S&LA	St Charles	IL	1/11/90	1/11/90	11/30/90
	08729	St. Charles FSA	St. Charles	IL			
8614	03437	Peoples Bank for Savings	Streator	IL	7/20/89	7/20/89	5/08/90
	08609	Peoples S&LA, FA	Streator	IL			
7735	02779	Summit First FS&LA	Summit	IL	7/13/90	7/13/90	10/26/90
	08870	Summit First S&LA, FA	Summit	IL			
8877	03238	First FS&LA of Tuscola	Tuscola	IL	8/17/90	8/17/90	6/07/91
	08910	First Federal SA of Tuscola	Tuscola	IL			
8296	06442	Home FS&LA of Lake County	Waukegan	IL	12/14/90	12/14/90	9/13/91
	09030	Home Federal Savings Bank, FA	Waukegan	IL			
7776	05524	Cooperative FS&LA	Westmont	IL	7/19/91	7/19/91	12/13/91
	09323	Co-operative FSB	Westmont	IL			
8227	02651	Horizon Federal Savings Bank	Wilmette	IL	1/11/90	1/11/90	3/08/91
	08718	Horizon Savings Bank, FSB	Wilmette	IL			
8276	05150	Hometown S&LA, FA	Winfield	IL	8/03/90	8/03/90	5/31/91
	08911	Hometown FS&LA	Winfield	IL			
7892	05230	First Savings Bank of Zion	Zion	IL	4/05/91	4/05/91	11/01/91
	09175	First Federal Savings Bank of Zion	Zion	IL			
8630	00004	First S&LA of Central Indiana	Anderson	IN	11/16/89	11/16/89	10/05/90
	08704	First FS&LA of Central Indiana	Anderson	IN			
8887	02211	Hometown Federal Savings Bank	Delphi	IN	6/08/90	6/08/90	12/14/90
	08863	Hometown SB, FSB	Delphi	IN			
7903	06654	First Commerce Bank, a FSB	Lowell	IN	6/14/91	6/14/91	2/07/92
	09242	First Commerce Savings Bank, FSB	Lowell	IN			
8573	01946	Pioneer FS&LA	Plymouth	IN	7/13/89	7/13/89	5/18/90
	08629	Pioneer Savings, FA	Plymouth	IN			
8382	04314	First FS&LA of Coffeyville	Coffeyville	KS		3/02/89	8/18/89
8676	03582	The Garnett S&LA	Garnett	KS		12/07/89	8/10/90
8387	00261	First of Kansas B&SA	Hays	KS	7/20/89	4/06/89	6/01/90
	08626	First of Kansas Savings, a FS&LA	Hays	KS			
8214	02171	The Hiawatha S&LA	Hiawatha	KS	3/09/90	3/09/90	11/16/90
	08770	The Hiawatha Federal Savings Association	Hiawatha	KS			
8380	03251	First FS&LA of Hutchinson	Hutchinson	KS		3/02/89	4/20/90
8377	01020	Valley FS&LA of Hutchinson	Hutchinson	KS	9/07/89	3/02/89	11/09/90
	08652	Valley Savings, a FS&LA	Hutchinson	KS			
8376	00382	Anchor SA	Kansas City	KS	8/31/89	2/17/89	6/22/90
	08632	Anchor FS&LA	Kansas City	KS			
8379	02172	Sun Savings Association, FA	Kansas City	KS		2/17/89	5/11/90
8386	06437	Colonial SA of America	Liberal	KS		3/02/89	9/22/89
8388	00178	The Barber County S&LA	Medicine Lodge	KS		3/02/89	5/04/90
8286	05909	First FSB of Newton	Newton	KS	5/10/91	5/10/91	10/28/91
	09225	First FSA of Newton	Newton	KS			

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8856	05149	Franklin SA	Ottawa	KS		2/16/90	
8385	00985	Mid-America FS&LA	Parsons	KS		3/02/89	5/04/90
8384	00424	Peoples S&LA	Parsons	KS		3/02/89	5/04/90
7732	02711	First FS&LA of Pittsburg	Pittsburg	KS	5/03/91	5/03/91	11/01/91
	09174	First FS&LA of Pittsburg, FA	Pittsburg	KS			
8298	06547	Colonial Savings, A FA	Prairie Village	KS	1/18/90	1/18/90	8/10/90
	08730	Colonial Federal Savings Association	Prairie Village	KS			
8575	02587	Peoples Heritage FS&LA	Salina	KS	8/10/89	8/10/89	1/12/90
	08648	Peoples Heritage Savings, A FS&LA	Salina	KS			
8378	02485	Shawnee FS&LA	Topeka	KS		3/02/89	5/18/90
8383	08447	Topeka Savings, a FS&LA	Topeka	KS		3/02/89	5/11/90
8381	03187	First FSB of Kansas	Wellington	KS		3/02/89	12/14/90
8576	02865	Mid Kansas FS&LA of Wichita	Wichita	KS	10/19/89	10/19/89	2/15/91
	08685	Mid Kansas S&LA, FA	Wichita	KS			
8689	00538	Henderson Home FS&LA	Henderson	KY	2/02/90	2/02/90	11/30/90
	08772	Henderson Home S&LA, FA	Henderson	KY			
7703	00422	Future FSB	Louisville	KY			8/30/91
8696	06180	United FS&LA	Prestonsburn	KY	8/30/91	8/30/91	11/22/91
	09417	United SB	Prestonsburg	KY			
7803	07168	Vermilion S&LA	Abbeville	LA	5/10/91	5/10/91	11/01/91
	09264	Vermilion Federal Savings Bank	Abbeville	LA			
8694	00759	Capital-Union Savings FA	Baton Rouge	LA	7/13/90	7/13/90	6/21/91
	08902	Capital-Union FSA	Baton Rouge	LA			
8407	07842	First City S&LA of Baton Rouge LA	Baton Rouge	LA	8/07/89	8/07/89	9/07/90
	08600	First City FS&LA	Baton Rouge	LA			
8404	06100	First FS&LA	Baton Rouge	LA		3/16/89	8/17/90
8400	07777	River City FSB	Baton Rouge	LA		3/16/89	10/06/89
8810	07091	First FS&LA	Breaux Bridge	LA	5/11/90	5/11/90	6/21/91
	08826	First FSA of Breaux Bridge	Breaux Bridge	LA			
8631	07513	Red River S&LA	Coushatta	LA	12/14/89	12/14/89	5/17/91
	08740	Red River FS&LA	Coushatta	LA			
8396	08436	Acadia S&LA, A FSA	Crowley	LA		3/16/89	10/06/89
8593	07690	Parish Federal Savings Bank	Denham Springs	LA	7/20/89	7/20/89	11/30/90
	08617	Parish FS&LA	Denham Springs	LA			
8409	07180	First FS&LA	Eunice	LA		3/16/89	5/11/90
8594	07504	Lafayette S&LA	Gretna	LA	7/27/89	7/27/89	6/01/90
	08611	Lafayette S&LA, FA	Gretna	LA			
8595	07809	Commercial Federal Savings Bank	Hammond	LA	7/27/89	7/27/89	5/31/91
	08612	Commercial S&LA, FA	Hammond	LA			
8402	07667	Elmwood FS&LA	Harahan	LA		3/02/89	9/08/89
8406	06867	Terrebonne S&LA	Houma	LA	8/07/89	8/07/89	12/07/90
	08625	Terrebonne S&LA, FA	Houma	LA			
8237	02959	Jennings FS&LA	Jennings	LA	5/18/90	5/18/90	8/02/91
	08851	Jennings Federal Savings Association	Jennings	LA			
8884	02406	Jonesboro FS&LA	Jonesboro	LA	5/18/90	5/18/90	8/15/91
	08840	Jonesboro FSA	Jonesboro	LA			
8394	07342	Delta S&LA	Kenner	LA	8/07/89	8/07/89	9/28/90
	08621	Delta FS&LA	Kenner	LA			
8408	08435	First Savings of Louisiana FSA	La Place	LA		3/02/89	9/15/89
8405	07885	Evangeline FS&LA	Lafayette	LA		3/16/89	8/18/89
8395	08088	First Louisiana FSB	Lafayette	LA	11/02/89	11/02/89	11/30/90
	08691	First Louisiana FSB, FA	Lafayette	LA			
8677	03457	Louisiana SA	Lake Charles	LA	12/14/89	12/14/89	9/13/91
	08741	Louisiana Savings Association, FA	Lake Charles	LA			
7723	02218	Desoto FS&LA	Mansfield	LA	11/02/90	11/02/90	9/06/91
	08960	Desoto Federal Savings Bank	Mansfield	LA			
8399	07702	Enterprise FS&LA	Marrero	LA		3/02/89	9/08/89
8632	04335	Columbia Homestead Association	Metairie	LA	10/13/89	10/13/89	8/30/91
	08679	Columbia Federal Homestead Association	Metairie	LA			
8820	07526	First FSB of New Orleans	Metairie	LA	6/15/90	6/15/90	7/26/91
	08883	First Savings Bank of New Orleans, FSB	Metairie	LA			
8392	08434	French Market Homestead FSA	Metairie	LA		2/17/89	9/14/90
8390	08299	Horizon FS&LA	Metairie	LA		2/17/89	5/18/90
8838	08031	Louisiana FSB	Metairie	LA	11/09/90	11/09/90	9/13/91
	08977	Louisiana Savings Bank, FSB	Kenner	LA			
8258	03584	Pelican Homestead & SA	Metairie	LA			1/31/92
8831	07876	Deposit Trust Savings Bank	Monroe	LA	1/11/90	1/11/90	12/07/90
	08722	Deposit Trust Federal Savings Bank	Monroe	LA			
8651	01053	People's Homestead FS for Savings	Monroe	LA	10/19/89	10/19/89	8/02/91
	08684	People's Homestead Savings Bank, FSB	Monroe	LA			
8246	03154	Progressive Federal Savings Bank	Natchitoches	LA	7/13/90	7/13/90	8/23/91
	08892	Progressive Savings Bank, FSB	Natchitoches	LA			
7804	07841	Oak Tree Savings Bank, SSB	New Orleans	LA	10/13/91	10/13/91	
	09471	Oak Tree Federal Savings Bank	New Orleans	LA			
8398	06345	First FS&LA	New Iberia	LA		3/16/89	9/28/90
8397	00225	American S&LA	New Orleans	LA	8/07/89	8/07/89	6/08/90
	08618	American S&LA, FA	New Orleans	LA			

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7949	03605	Carrollton Homestead Association	New Orleans	LA	3/13/92	3/13/92	
	09723	Carrollton Homestead Association, FA	New Orleans	LA			
8401	04230	Central S&LA	New Orleans	LA	8/07/89	8/07/89	6/22/90
	08605	Central S&LA, FA	New Orleans	LA			
8538	00215	Citizens Homestead Association	New Orleans	LA	8/07/89	8/07/89	6/07/91
	08601	Citizens Homestead FSA	New Orleans	LA			
8269	04228	Commonwealth SA	New Orleans	LA	7/20/90	7/20/90	7/12/91
	08889	Commonwealth FSA	New Orleans	LA			
7713	01022	Dryades S&LA	New Orleans	LA	6/07/91	6/07/91	
	09240	Dryades S&LA, FA	New Orleans	LA			
8577	04231	Home S&LA	New Orleans	LA	8/07/89	8/07/89	6/22/90
	08623	Home S&LA, FA	New Orleans	LA			
8389	01205	Security Homestead Association	New Orleans	LA	8/07/89	8/07/89	5/24/91
	08606	Security Homestead FSA	New Orleans	LA			
7710	01302	Southern Savings Bank, FSB	New Orleans	LA	12/28/90	12/28/90	9/27/91
	09031	Southern Federal Savings Bank	New Orleans	LA			
8809	06997	United FS&LA	New Orleans	LA	3/16/90	3/16/90	9/28/90
	06798	United Federal Savings, FA	New Orleans	LA			
8539	07804	Family FS&LA	Shreveport	LA		3/16/89	6/15/90
8393	00025	First FS&LA	Shreveport	LA		3/16/89	12/07/90
8403	07747	Fontainebleau FSB	Slidell	LA		3/02/89	6/01/90
8391	04161	South S&LA	Slidell	LA	8/07/89	8/07/89	6/14/91
	08620	South S&LA, FA	Slidell	LA			
8410	07508	Peoples FS&LA of Thibodaux	Thibodaux	LA		3/16/89	5/11/90
8300	06642	United FS&LA	Vidalia	LA			7/20/90
8234	02941	First FS&LA	Winnfield	LA	8/31/90	8/31/90	9/06/91
	08903	First Federal Savings Association	Winnfield	LA			
8879	03696	Home Owners Savings Bank FSB	Boston	MA		4/27/90	9/07/90
7863	01450	Sentry Federal Savings Bank	Hyannis	MA	9/21/90	9/21/90	7/26/91
	08942	Sentry Federal Bank, FSB	Hyannis	MA			
7745	03483	Comfed Savings Bank	Lowell	MA	2/01/91	12/14/90	9/13/91
	09051	Comfed Savings Bank, FA	Lowell	MA			
7911	03487	Plymouth Federal Savings Bank	Plymouth	MA	9/27/91	9/27/91	
	09467	Plymouth Federal Savings Association	Plymouth	MA			
8665	05269	Home Federal Savings Bank	Worcester	MA	6/08/90	6/08/90	11/09/90
	08871	Home FSB of Worcester	Worcester	MA			
8204	01557	First Annapolis Savings Bank, FSB	Annapolis	MD	6/01/90	6/01/90	5/03/91
	08820	First FSB of Annapolis	Annapolis	MD			
8412	08275	Gibraltar Federal Savings Bank, FSB	Annapolis	MD	7/11/89	3/02/89	6/08/90
	08610	Gibraltar S&LA, FA	Annapolis	MD			
7752	04142	Augusta Federal Savings Bank	Baltimore	MD	4/26/91	4/26/91	3/20/92
	09163	Augusta Federal Savings Association	Baltimore	MD			
8411	01718	Baltimore Federal Financial FSA	Baltimore	MD		2/07/89	4/20/90
7936	01903	Irvington FS&LA	Baltimore	MD	2/28/92	2/28/92	
	09700	Irvington Federal Savings Bank	Glen Burnie	MD			
8666	05728	Yorkridge-Calvert S&LA	Baltimore	MD	12/14/89	12/14/89	9/28/90
	08701	Yorkridge-Calvert FSA	Baltimore	MD			
7844	08204	John Hanson Savings Bank, FSB	Beltsville	MD	4/26/91	4/26/91	
	09167	John Hanson Federal Savings Bank	Beltsville	MD			
8578	08366	Liberty Federal Savings Bank	Randallstown	MD	2/09/90	2/09/90	1/04/91
	08755	Liberty Savings Bank, FSB	Randallstown	MD			
8212	01999	Royal Oak FS&LA	Randallstown	MD			1/04/91
7851	08455	Republic Federal Savings Bank	Rockville	MD	3/22/91	3/22/91	2/28/92
	09098	Republic Savings Bank, FSB	Rockville	MD			
8268	04177	Vermont FS&LA	Timonium	MD	2/09/90	2/09/90	6/28/91
	08756	Vermont Savings Association, FA	Timonium	MD			
7956	03823	First FS&LA	Lewiston	ME	5/21/92	5/21/92	
	09977	First FSA	Lewiston	ME			
8664	01398	American Bank, FSB	Sanford	ME	1/11/90	1/11/90	9/13/91
	08717	American Federal Savings Bank	Sanford	ME			
7898	04100	Ludington Savings Bank, FSB	Ludington	MI	5/17/91	5/17/91	2/07/92
	09230	Ludington Federal Savings Bank	Ludington	MI			
7740	03310	First Federal Savings Bank & Trust	Pontiac	MI	10/16/91	10/16/91	
	09472	First FS&LA	Pontiac	MI			
8414	00322	Peoples SA, FA	St Joseph	MI		3/09/89	2/02/90
8579	05424	Guaranty Federal Savings Bank	Taylor	MI	7/27/89	7/27/89	4/27/90
	08598	New Guaranty FS&LA	Taylor	MI			
8238	02979	Lakeland Federal Savings Bank	Detroit Lakes	MN	3/16/90	3/16/90	8/24/90
	08789	Lakeland Savings Bank, FSB	Detroit Lakes	MN			
8698	01139	Fairmont FS&LA	Fairmont	MN	2/09/90	2/09/90	9/07/90
	08752	Fairmont FSA	Fairmont	MN			
8521	05518	Midwest FS&LA of Minneapolis	Minneapolis	MN	5/04/89	2/13/89	10/05/90
	08574	Midwest Savings Association, FA	Minneapolis	MN			
8231	02817	First FS&LA of Thief River Falls	Thief River Falls	MN			8/09/91
8241	03058	United Federal Savings Bank	Windom	MN	5/11/90	5/11/90	7/06/90
	08827	United Savings Bank, FSB	Windom	MN			
8291	06209	Boonslick S&LA	Boonville	MO	11/02/90	11/02/90	5/24/91

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8419	08956	Boonslick FS&LA	Boonville	MO			
	06263	Mid Missouri S&LA	Boonville	MO	6/29/89	6/29/89	4/27/90
	08589	Mid Missouri S&LA, FA	Boonville	MO			
8275	05147	Colonial FS&LA	Cape Girardeau	MO	1/26/90	1/26/90	11/09/90
	08737	Colonial S&LA, FA	Cape Girardeau	MO			
8417	00259	First Federal S&LA of Southeast MO	Cape Girardeau	MO			
8416	01893	Missouri Savings Association	Clayton	MO	6/29/89	6/29/89	9/07/90
	08588	Missouri Savings Association, FA	Clayton	MO			
8225	02637	St. Louis County FS&LA of Ferguson	Ferguson	MO	1/11/90	1/11/90	6/28/90
	08714	St. Louis County SA, FA	Ferguson	MO			
8420	02769	Cass FS&LA of St. Louis	Florissant	MO		4/06/89	6/22/90
8418	03485	Financial FS&LA	Joplin	MO		4/06/89	4/27/90
8415	00658	Blue Valley FS&LA	Kansas City	MO		2/17/89	6/15/90
8869	01243	First Savings Bank & Trust, FSB	Kansas City	MO	5/04/90	5/04/90	7/06/90
	08852	First Federal Savings Bank & Trust	Kansas City	MO			
8232	02882	Home SA of Kansas City, FA	Kansas City	MO	3/15/91	3/15/91	3/27/92
	09093	Home Federal Savings of Kansas City	Kansas City	MO			
7869	03702	First State SA	Sedalia	MO			4/03/92
8217	02403	Community FS&LA	St. Louis	MO			12/14/90
8894	00064	New Age FS&LA of St. Louis	St. Louis	MO	8/23/91	8/23/91	3/19/92
	09389	New Age Federal Savings Association	St. Louis	MO			
8880	08235	Mississippi Savings Bank	Batesville	MS	5/08/90	5/08/90	12/14/90
	08841	Mississippi Savings Bank, FSB	Batesville	MS			
7889	04401	Peoples FS&LA	Bay St. Louis	MS	2/08/91	2/08/91	8/09/91
	09057	Peoples Federal Savings Association	Bay St. Louis	MS			
8803	06702	First FS&LA of Brookhaven	Brookhaven	MS	1/18/90	1/18/90	7/12/91
	08738	Brookhaven FS&LA	Brookhaven	MS			
8421	08061	Fidelity FSB	Corinth	MS		4/06/89	5/04/90
8862	07511	Great American Federal S&LA	Corinth	MS	3/16/90	3/16/90	12/14/90
	08792	Great American S&LA, FA	Corinth	MS			
8425	07538	Delta FS&LA	Drew	MS		4/06/89	6/29/90
8289	06016	First FS&LA	Greenwood	MS	2/23/90	2/23/90	5/31/91
	08765	Greenwood Federal S&LA	Greenwood	MS			
8891	07500	Southern Federal Bank for Savings	Gulfport	MS	6/22/90	6/22/90	8/16/91
	08860	Southern Federal Savings Bank	Gulfport	MS			
8870	08001	Charter Bank, a Federal Savings Bank	Hattiesburg	MS	7/20/90	7/20/90	7/26/91
	08894	Charter Savings Bank, FSB	Hattiesburg	MS			
8821	07588	First Guaranty Bank for Savings	Hattiesburg	MS	1/04/90	1/04/90	6/14/91
	08712	First Guaranty FS&LA	Hattiesburg	MS			
8422	07514	Central S&LA	Jackson	MS		4/06/89	9/28/90
8812	07289	First Jackson Savings Bank, FSB	Jackson	MS	6/29/90	6/29/90	7/12/91
	08864	First Jackson Federal Savings Bank	Jackson	MS			
8423	07152	Republic Bank for Savings, FA	Jackson	MS		4/06/89	6/29/90
8426	06614	State Mutual FS&LA	Jackson	MS		4/06/89	5/11/90
8623	02873	Unifirst Bank for Savings, FA	Jackson	MS	8/10/89	8/10/89	6/15/90
	08637	Unifirst Bank for Savings, A FS&LA	Jackson	MS			
8876	07580	Southeastern Savings Bank	Laurel	MS	4/20/90	4/20/90	5/31/91
	08811	Southeastern Federal Savings Bank	Waynesboro	MS			
7812	07570	First City FS&LA	Lucedale	MS	9/07/90	9/07/90	7/19/91
	08923	First City Federal Savings Bank	Lucedale	MS			
7896	07598	Mercantile Savings Bank	Southaven	MS	4/19/91	4/19/91	10/25/91
	09168	Mercantile Federal Savings Bank	Southaven	MS			
8817	07414	North Carolina FS&LA	Charlotte	NC	3/02/90	3/02/90	9/21/90
	08769	North Carolina S&LA, FA	Charlotte	NC			
7842	08166	Southeastern Savings Bank, Inc.	Charlotte	NC	11/16/90	11/16/90	9/20/91
	08969	Southeastern Federal Savings Bank	Charlotte	NC			
8684	00284	Guaranty Federal Savings Bank	Fayetteville	NC	7/27/90	7/27/90	6/14/91
	08872	Guaranty Savings Bank, FSB	Fayetteville	NC			
8259	03722	First American Savings Bank, FSB	Greensboro	NC	6/05/92	6/05/92	
	09982	First American FSB	Greensboro	NC			
7841	08162	Preferred S&LA, Inc.	High Point	NC	3/08/91	3/08/91	9/27/91
	09085	Preferred Savings Bank, FSB	High Point	NC			
8428	08229	Great Atlantic Savings Bank FSB	Manteo	NC		3/30/89	9/15/89
8427	05634	Heritage FS&LA	Monroe	NC		3/30/89	9/21/90
7857	08459	Surety FS&LA, FSA	Morganton	NC	7/09/91	7/09/91	
	09318	Surety FS&LA, FA	Morganton	NC			
7756	04426	First FS&LA	Raleigh	NC	12/07/90	12/07/90	3/06/92
	09021	First FSA of Raleigh	Raleigh	NC			
8226	02638	First FS&LA of Bismarck	Bismarck	ND	1/26/90	1/26/90	9/21/90
	08746	First Saving Association, FA	Bismarck	ND			
7708	01263	First FS&LA of Fargo	Fargo	ND	5/10/91	5/10/91	11/01/91
	09226	First FS&LA of Fargo, FA	Fargo	ND			
8690	00546	Midwest Federal Savings Bank	Minot	ND	1/04/90	1/04/90	9/21/90
	08745	Midwest FSB of Minot	Minot	ND			
8804	06728	Equitable S&LA, FA	Columbus	NE	2/16/90	2/16/90	6/22/90
	08757	Equitable FS&LA	Columbus	NE			
8432	04379	Equitable FSB	Fremont	NE		2/17/89	11/16/90

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8431	03396	Platte Valley FS&LA	Gering	NE	7/13/89	2/17/89	5/11/90
	08630	Platte Valley Savings, A FS&LA	Gering	NE			
8433	02988	Midwest FS&LA	Nebraska City	NE		2/17/89	5/18/90
8248	03273	Heritage FSB	Omaha	NE	2/16/90	2/16/90	11/30/90
	08760	Heritage FSB of Omaha	Omaha	NE			
8430	04906	Occidental Nebraska FSB	Omaha	NE	7/13/89	2/17/89	6/22/90
	08603	Occidental Nebraska Savings Bank, FSB	Omaha	NE			
8434	05492	Nile Valley FS&LA	Scottsbluff	NE		2/17/89	9/15/89
8673	06017	First FS&LA of York	York	NE	1/18/90	1/18/90	6/22/90
	08726	First FSA of York	York	NE			
7913	02664	Home Bank, FSB	Berlin	NH	10/10/91	10/10/91	
	09468	Homebank Federal Savings Association	Gilford	NH			
7891	03348	First Northern Cooperative Bank	Keene	NH	2/20/91	2/20/91	8/02/91
	09078	First Northern Co-Op Bank, A FSB	Keene	NH			
7764	04881	Center S&LA	Clifton	NJ	1/25/91	1/25/91	9/20/91
	09050	Center S&LA, FA	Clifton	NJ			
8438	05248	Metropolitan FS&LA	Denville	NJ		4/27/89	9/28/90
7788	06268	Hansen Savings Bank, SLA	East Brunswick	NJ	1/10/92	1/10/92	
	09618	Hansen Federal Savings Association	Hammonton	NJ			
7865	01531	City Federal Savings Bank	Elizabeth	NJ	12/08/89	12/08/89	1/11/91
	08734	City Savings Bank, FSB	Bedminster	NJ			
7865	01531	City Federal Savings Bank	Elizabeth	NJ	12/08/89	9/21/90	1/11/91
	08943	City Savings, FSB	Bedminster	NJ			
7866	01659	Empire Savings Bank, SLA	Hammonton	NJ	12/14/90	12/14/90	10/11/91
	09037	Empire Savings Bank, FSB	Hammonton	NJ			
8436	07133	Elysian FSB	Hoboken	NJ		2/17/89	6/29/90
7816	08032	Amerifederal Savings Bank	Lawrenceville	NJ	3/01/91	3/01/91	9/20/91
	09082	Amerifederal Savings Bank, FSB	Lawrenceville	NJ			
8242	00182	Volunteer Savings Bank SLA	Little Ferry	NJ	6/05/92	6/05/92	
	09980	Volunteer FSA	Little Ferry	NJ			
8874	04809	Mutual Aid S&LA	Manasquan	NJ	5/04/90	5/04/90	8/16/91
	08843	Mutual Aid FS&LA	Manasquan	NJ			
8278	05279	Yorkwood S&LA	Maplewood	NJ	3/09/90	3/09/90	10/18/91
	08780	Yorkwood FS&LA	Warren	NJ			
7928	04590	Marine View Savings Bank, SLA	Middletown	NJ	11/01/91	11/01/91	
	09499	Marine View Federal Savings Bank	Middletown	NJ			
7876	06067	Trident FS&LA	Newark	NJ	1/04/91	1/04/91	8/02/91
	09043	Trident FS&LA, FA	Newark	NJ			
7797	06497	Newton Savings Bank, SLA	Newton	NJ	5/03/91	5/03/91	3/20/92
	09172	Newton Savings Bank, FSB	Fairfield	NJ			
8890	02264	Nutley S&LA	Nutley	NJ			9/27/91
8885	05866	Metrobank for Savings FSB	Palisades Park	NJ	6/28/91	6/28/91	4/10/92
	09289	Metrobank FS&LA	Palisades Park	NJ			
8435	04636	North Jersey S&LA	Passaic	NJ	12/21/90	2/17/89	6/07/91
	09039	North Jersey FSA	Passaic	NJ			
7761	04826	Alexander Hamilton S&LA of Paterson	Paterson	NJ	3/08/91	3/08/91	9/13/91
	09088	Alexander Hamilton FS&LA	Paterson	NJ			
8272	04825	Irving S&LA	Paterson	NJ	1/18/91	1/18/91	2/21/92
	09047	Irving FS&LA	Paterson	NJ			
8882	04839	United Savings Bank, SLA	Paterson	NJ	5/15/90	5/15/90	12/13/90
	08837	United Savings, FSB	Paterson	NJ			
8681	00202	First Atlantic S&LA	Plainfield	NJ	6/22/90	2/23/90	9/13/91
	08862	First Atlantic FSA	South Plainfield	NJ			
8287	05931	Nassau S&LA	Princeton	NJ	3/09/90	3/09/90	8/23/91
	08778	Nassau FS&LA	Princeton	NJ			
7762	04827	Mainstay Federal Savings Bank	Red Bank	NJ	7/20/90	7/20/90	9/27/91
	08893	Mainstay Federal Savings, FSB	Red Bank	NJ			
7777	05606	Riverside Savings Bank, SLA	Riverside	NJ	11/02/90	11/02/90	10/04/91
	08957	Riverside Federal Savings Bank	Riverside	NJ			
8659	04916	Colonial Savings Bank, SLA	Roselle Park	NJ	11/09/89	11/09/89	7/05/91
	08693	Colonial Federal Savings Association	Roselle Park	NJ			
7884	04995	Action Savings Bank, SLA	Somers Point	NJ	11/15/90	11/15/90	10/25/91
	08976	Action Federal Savings Bank	Somers Point	NJ			
7720	01900	Mercer Savings Bank S&LA	Trenton	NJ	9/21/90	9/21/90	8/02/91
	08930	Mercer Federal Savings Bank	Trenton	NJ			
8282	05679	Old Borough S&LA	Trenton	NJ	12/14/90	12/14/90	8/23/91
	09029	Old Borough FS&LA	Trenton	NJ			
8853	00005	The United S&LA of Trenton, NJ	Trenton	NJ	6/15/90	6/15/90	9/06/91
	08881	United Savings and Loan of Trenton, FA	Trenton	NJ			
7914	05711	White Horse S&LA	Trenton	NJ	11/22/91	11/22/91	
	09565	White Horse FS&LA	Trenton	NJ			
7775	04188	Prospect Park Savings Bank, SLA	West Paterson	NJ	4/19/91	4/19/91	
	09158	Prospect Park Federal Savings Bank	West Paterson	NJ			
7707	00997	First Jersey S&LA	Wyckoff	NJ	2/08/91	2/08/91	9/13/91
	09056	First Jersey Savings, FA	Wyckoff	NJ			
8236	02953	ABQ Bank, A Federal Savings Bank	Albuquerque	NM	3/16/90	2/09/90	3/01/91
	08797	ABQ Federal Savings Bank	Albuquerque	NM			

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Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv date	Resolution date
8441	06675	American FS&LA	Albuquerque	NM		3/09/89	6/08/90
8580	06785	New Mexico Federal Savings & Loan	Albuquerque	NM	7/20/89	7/20/89	6/15/90
	08616	New Mexico FSA	Albuquerque	NM			
8439	06441	Sandia FS&LA	Albuquerque	NM	9/13/89	2/10/89	3/01/91
	08646	Sandia Federal Savings Association	Albuquerque	NM			
8848	08236	Security FS&LA of Albuquerque	Albuquerque	NM	5/03/91	5/03/91	3/13/92
	09169	Security FS&LA, FA	Albuquerque	NM			
8443	07749	Sun Country SB of New Mexico, FSB	Albuquerque	NM		3/09/89	5/31/90
8807	06957	Security Savings Bank, FSB	Carlsbad	NM	5/04/90	5/04/90	11/16/90
	08813	Security Federal Savings Bank	Albuquerque	NM			
8244	03100	First FS&LA	Las Vegas	NM	11/16/90	11/16/90	6/21/91
	08975	First Federal Savings Association	Las Vegas	NM			
8442	05320	Valley Federal Savings Bank	Roswell	NM	8/30/89	3/09/89	6/08/90
	08645	Valley Savings Bank, FSB	Roswell	NM			
8866	07813	First American Savings Bank, FSB	Santa Fe	NM	8/31/90	8/31/90	11/30/90
	08900	First American FSB	Santa Fe	NM			
8633	07595	Silver S&LA, A Federal Association	Silver City	NM	12/21/89	12/21/89	1/18/91
	08699	Silver Savings Association, FA	Silver City	NM			
7792	06429	Frontier SA	Las Vegas	NV			12/14/90
7736	02810	Beacon Federal Savings Bank	Baldwin	NY	3/08/91	3/08/91	10/18/91
	09084	Beacon Federal Savings Association	Baldwin	NY			
7864	03269	Yorkville FS&LA	Bronx	NY	9/21/90	9/21/90	9/20/91
	08944	Yorkville FSA	Bronx	NY			
8235	02947	Nassau FS&LA	Brooklyn	NY	3/16/90	3/16/90	11/16/90
	08809	Nassau Savings and Loan Association	Brooklyn	NY			
8277	05160	Empire of America FSB	Buffalo	NY	2/28/90	1/24/90	9/28/90
	08790	Empire Federal Savings Bank of America	Buffalo	NY			
7894	01747	State Savings, FA	Jamaica Estates North	NY	3/22/91	3/22/91	3/27/92
	09096	State Savings, FSB	Jackson Heights	NY			
7759	01901	Larchmont FS&LA	Larchmont	NY			8/09/91
8267	04153	Central Federal Savings FSB	Long Beach	NY	12/07/90	12/07/90	3/13/92
	09024	Central Federal Savings Bank	Long Beach	NY			
7733	02750	Edison FS&LA	New York	NY	11/30/90	11/30/90	8/30/91
	09020	Edison Federal Savings Association	New York	NY			
8836	07966	Ensign Bank, FSB	New York	NY	8/31/90	8/31/90	7/19/91
	08898	Ensign Federal Savings Bank	New York	NY			
7919	04209	Columbia Banking FS&LA	Rochester	NY	6/12/92	6/12/92	
	04209	Columbia Banking FSA	Rochester	NY			
8670	03445	Salamanca FS&LA	Salamanca	NY	11/30/89	11/30/89	8/17/90
	08702	Salamanca Federal Savings Association	Salamanca	NY			
7746	03671	Eastern FS&LA of Sayville	Sayville	NY			9/27/91
8205	00753	Westerleigh Savings, A FS&LA	Staten Island	NY	5/31/91	5/31/91	3/27/92
	09236	Westerleigh FS&LA	Staten Island	NY			
8273	04925	Whitestone Savings, FA	Whitestone	NY	3/16/90	3/16/90	11/16/90
	08787	Whitestone FS&LA	Whitestone	NY			
8444	03899	Midland-Buckeye FS&LA	Alliance	OH	9/14/89	3/30/89	9/07/90
	08655	Midland-Buckeye Savings, A FS&LA	Alliance	OH			
7751	03939	Arcanum FS&LA	Arcanum	OH	3/15/91	3/15/91	9/20/91
	09091	Arcanum Federal Savings Association	Arcanum	OH			
8542	01703	Broadview Savings Bank	Cleveland	OH	8/24/89	3/30/89	5/18/90
	08639	Broadview Federal Savings Bank	Cleveland	OH			
7714	01640	Superior Savings Association	Cleveland	OH	10/23/90	10/23/90	9/27/91
	08973	Superior FSA	Cleveland	OH			
8687	00388	Freedom FS&LA	Columbus	OH	2/16/90	2/16/90	8/09/91
	08759	Freedom Savings Association, FA	Columbus	OH			
7726	02359	Mid-America FS&LA	Columbus	OH			12/15/90
7712	01410	Columbia FS&LA	Hamilton	OH	4/05/91	4/05/91	11/01/91
	09120	Columbia FSA of Hamilton	Hamilton	OH			
8683	05750	Liberty SB&L Co.	Marietta	OH	5/03/91	5/03/91	1/31/92
	09171	Liberty Savings Bank, FSB	Marietta	OH			
7706	00795	Pioneer S&L Co.	Marietta	OH	6/29/90	6/29/90	11/16/90
	08873	Pioneer FS&LA	Marietta	OH			
8203	01339	First S&L Co.	Massillon	OH	4/20/90	4/20/90	7/19/91
	08818	First Savings and Loan Co., FA	Massillon	OH			
7701	00376	First FS&LA	Mt Vernon	OH			8/23/91
8581	01981	Civic Savings Bank	Portsmouth	OH	12/14/90	6/08/89	8/02/91
	09032	Civic Federal Savings Bank	Portsmouth	OH			
8871	00126	Merchants and Mechanics FS&LA	Springfield	OH			8/23/91
7938	03011	First Ohio SB, FSB	St Bernard	OH			3/13/92
7888	03427	First FS&LA	Toledo	OH	2/28/91	2/01/91	9/27/91
	09083	First Federal SA of Toledo	Toledo	OH			
7742	03412	United Home Federal	Toledo	OH			9/06/91
7895	07299	American FS&LA of ADA	ADA	OK	3/22/91	3/22/91	11/01/91
	09101	American Savings Bank, FSB	ADA	OK			
8274	05081	Peoples FS&LA	Bartlesville	OK	3/09/90	3/09/90	12/14/90
	08753	Peoples Federal Savings Association	Bartlesville	OK			
8260	03743	Broken Arrow FS&LA	Broken Arrow	OK	8/24/90	8/24/90	6/07/91

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Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8605	08915	Broken Arrow SA, FA	Broken Arrow	OK			
	07912	Cross Roads S&LA	Checotah	OK	7/13/89	7/13/89	5/11/90
	08627	Cross Roads FS&LA FA	Checotah	OK			
8210	01937	First FS&LA of Chickasha	Chickasha	OK	3/22/91	3/22/91	2/07/92
	09097	First FSA of Chickasha	Chickasha	OK			
8270	04540	Clinton S&LA	Clinton	OK			7/19/91
8546	04585	The Duncan S&LA	Duncan	OK		3/16/89	8/17/90
8641	07907	American Home S&LA	Edmond	OK	10/05/89	10/05/89	9/12/90
	08675	American Home S&LA, FA	Edmond	OK			
8608	08518	Chisholm FS&LA	Kingfisher	OK	4/19/91	4/19/91	3/20/92
	09160	Chisholm FSA	Kingfisher	OK			
8609	08520	Red River FS&LA	Lawton	OK	4/26/91	4/26/91	3/27/92
	09162	Red River FS&LA, FA	Lawton	OK			
8610	08511	Cimarron FS&LA	Muskogee	OK	4/19/91	4/19/91	
	09159	Cimarron FSA	Muskogee	OK			
8445	00817	Continental FS&LA	Oklahoma City	OK	7/13/89	3/16/89	8/09/91
	08604	Continental FS&LA, FA	Oklahoma City	OK			
8446	01819	Family FSB	Sapulpa	OK	10/05/89	10/05/89	5/25/90
	08676	Family Savings Bank, FSB	Sapulpa	OK			
8447	02954	First FS&LA of Seminole	Seminole	OK		3/16/89	9/21/90
8655	02036	Sooner FS&LA	Tulsa	OK	11/16/89	11/16/89	9/14/90
	08690	Sooner Federal Savings Association	Tulsa	OK			
8202	01228	State FS&LA	Tulsa	OK	2/16/90	2/16/90	8/16/91
	08761	State FSA	Tulsa	OK			
8582	02159	Great Plains FS&LA of Weatherford	Weatherford	OK	10/26/89	10/26/89	8/17/90
	08689	Great Plains Savings Association, FA	Weatherford	OK			
7760	02773	First FS&LA of Wewoka	Wewoka	OK	3/08/91	3/08/91	8/02/91
	09086	First FSA of Wewoka	Wewoka	OK			
8667	02514	Family FS&LA	Dallas	OR	1/11/90	1/11/90	6/22/90
	08731	Family FSA	Dallas	OR			
8243	03091	Far West Federal Bank, SB	Portland	OR	6/07/91	5/23/91	
	09239	Far West Federal Savings Bank	Portland	OR			
8201	01165	The Benjamin Franklin FS&LA	Portland	OR		2/21/90	9/07/90
8661	02555	Atlantic Financial Federal	Bala Cynwyd	PA	1/11/90	1/11/90	11/15/91
	08721	Atlantic Financial Savings, FA	Bala Cynwyd	PA			
8450	05166	Liberty Bell SA	Beaver Falls	PA		3/09/89	12/15/89
7915	02564	Abraham Lincoln Federal Savings Bank	Dresher	PA	9/19/91	9/19/91	
	09422	Abraham Lincoln FSA	Dresher	PA			
7728	02521	Home Unity S&LA	Lafayette Hill	PA	6/04/92	6/04/92	
	09979	Home Unity FS&LA	Lafayette Hill	PA			
7815	07649	Heritage SA	Lancaster	PA	7/06/90	7/06/90	5/31/91
	0888	Heritage Federal SA	Lancaster	PA			
7926	07223	Homestead SA	Middletown	PA	8/30/91	8/30/91	
	09418	Homestead Federal SA	Middletown	PA			
8668	00371	Colony Savings Bank, FSB	Monaca	PA	4/05/90	4/05/90	10/11/91
	08810	Colony Federal Savings Bank	Monaca	PA			
8449	00472	Concord-Liberty S&LA	Monroeville	PA	9/21/89	3/09/89	12/15/89
	08663	Concord-Liberty FS&LA	Monroeville	PA			
7750	03806	Peoples FS&LA	New Kensington	PA	3/01/91	3/01/91	9/06/91
	09081	Peoples Federal Savings Bank	New Kensington	PA			
7939	06590	Alpha Indian Rock S&LA	Philadelphia	PA	2/28/92	2/28/92	
	09698	Alpha Indian Rock FS&LA	Manayunk	PA			
7924	05164	Chase S&LA	Philadelphia	PA	11/22/91	11/22/91	
	09566	Chase FS&LA	Philadelphia	PA			
7940	06013	Ukrainian S&LA	Philadelphia	PA	3/12/92	3/12/92	
	09722	Ukrainian Federal S&LA	Philadelphia	PA			
8240	03014	First FS&LA of Pittsburgh	Pittsburgh	PA			1/04/91
7927	01233	First Home SA	Pittsburgh	PA	6/19/92	6/19/92	
	01233	First Home FSA	Pittsburgh	PA			
8541	04944	Hill Financial SA	Red Hill	PA		3/09/89	10/13/89
8583	04159	Horizon Financial, FA	Southampton	PA		6/08/89	5/25/90
7902	05516	Springfield FA&LA	Springfield	PA	6/14/91	6/14/91	3/20/92
	09241	Springfield FSA	Springfield	PA			
7893	02371	Bell S&LA	Upper Darby	PA	3/19/91	3/15/91	3/20/92
	09095	Bell Federal Savings Bank	Upper Darby	PA			
8252	03474	Vanguard Federal Savings Bank	Vandergrift	PA	2/23/90	2/23/90	7/05/91
	08781	Vanguard Savings Bank, FSB	Vandergrift	PA			
8865	06344	Caguas-Central FSB of Puerto Rico	Caguas	PR		5/25/90	8/31/90
7890	08404	Colonial Bank	Cranston	RI	5/10/91	5/10/91	3/13/92
	09228	Colonial Federal Savings Bank	Cranston	RI			
8257	02481	Cooper River FS&LA	Charleston Heights	SC	6/05/92	6/05/92	
	09981	Cooper River FSA	North Charleston	SC			
7957	07972	First South Savings Bank	Columbia	SC	4/24/92	4/24/92	
	09884	First South FSB	Columbia	SC			
8671	02843	Security Federal Savings Bank	Columbia	SC	11/30/89	11/30/89	2/15/91
	08709	Security Federal Savings, FSB	Columbia	SC			
8892	00006	Standard Federal Savings Bank	Columbia	SC	8/02/91	8/02/91	

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8559	09386	Standard FS&LA	Columbia	SC			
	08027	Seabank Savings, FSB	Myrtle Beach	SC	9/20/89	4/27/89	12/19/89
	08664	Seabank FSB	Myrtle Beach	SC			
7785	06178	First Federal Bank FSB	Huron	SD	3/08/91	3/08/91	9/13/91
	09087	First Federal Savings Bank	Huron	SD			
7702	00392	First FSB of South Dakota	Rapid City	SD			4/24/92
8566	02884	Cherokee Valley Federal Savings Bank	Cleveland	TN	6/12/92	6/12/92	
	02884	Cherokee Valley FSA	Cleveland	TN			
8875	07534	The Tennessee Savings Bank	Cookeville	TN	8/03/90	8/03/90	5/31/91
	08913	Tennessee Federal Savings Bank	Cookeville	TN			
8540	07562	Germantown Trust Savings Bank	Germantown	TN		3/09/89	5/18/90
7886	07542	George Washington S&LA Inc.	Jonesboro	TN	2/01/91	2/01/91	7/05/91
	09042	George Washington FSA	Jonesboro	TN			
8584	00664	Home FS&LA	Memphis	TN		7/20/89	6/15/90
8451	07549	Lincoln FS&LA	Mt Carmel	TN		3/09/89	6/15/90
8860	07556	Investor Federal Savings Bank	Nashville	TN	3/09/90	3/09/90	6/07/91
	08771	Investors Savings Bank, FSB	Nashville	TN			
8679	05271	Metropolitan FS&LA	Nashville	TN	4/19/91	4/19/91	3/27/92
	09161	Metropolitan FS&LA, FA	Nashville	TN			
8543	03946	Century FSB	Trenton	TN		3/09/89	6/15/90
8453	07512	United Guaranty FSB	Tulahoma	TN		3/09/89	5/04/90
7748	03703	First FS&LA	Waynesboro	TN	2/08/91	2/08/91	8/09/91
	09055	First FSA of Waynesboro	Waynesboro	TN			
8491	07840	Palo Duro S&LA	Amarillo	TX	1/26/90	1/26/90	5/17/91
	08744	Palo Duro FS&LA	Amarillo	TX			
8293	06315	Andrews S&LA	Andrews	TX	12/07/90	12/07/90	9/06/91
	09022	Andrews FS&LA	Andrews	TX			
7836	08052	Centre Savings Association	Arlington	TX	8/16/91	8/16/91	2/21/92
	09387	Centre Savings Association, FA	Arlington	TX			
8488	07784	Meridian SA	Arlington	TX		4/06/89	4/13/90
8295	06439	The Savings Banc, A S&LA	Arlington	TX	5/11/90	5/11/90	8/09/91
	08832	The Federal Savings Banc, FA	Beaumont	TX			
8254	03546	Atlanta FS&LA	Atlanta	TX	8/31/90	8/31/90	6/14/91
	08899	Atlanta Federal Savings Association	Atlanta	TX			
8505	08072	American FSB	Austin	TX		4/06/89	9/08/89
8585	08091	Austin Savings Association	Austin	TX	11/30/89	11/30/89	6/26/91
	08706	Austin FS&LA	Austin	TX			
8616	07278	Capitol City SA	Austin	TX	7/27/89	7/27/89	9/14/90
	08608	Capitol City FSA	Austin	TX			
7833	08018	Fidelity Savings—Austin, FA	Austin	TX	7/12/91	7/12/91	2/07/92
	09320	Fidelity FS&LA	Austin	TX			
8498	07719	Southside S&LA	Austin	TX	8/17/90	8/17/89	6/08/90
	08651	Southside FS&LA	Austin	TX			
9935	079942	Windsor Savings Association	Austin	TX	6/29/90	6/29/90	7/12/91
	08859	Windsor Federal Savings Association	Austin	TX			
8472	07489	Western Gulf S&LA	Bay city	TX		3/09/89	11/08/90
8492	07364	Century S&LA	Baytown	TX		3/09/89	8/18/89
8487	06475	Citizens of Texas S&LA	Baytown	TX		3/09/89	8/10/90
8893	00028	First FS&LA	Beaumont	TX			9/27/91
8476	06882	Jefferson S&LA	Beaumont	TX		3/16/89	8/24/90
8471	07883	Spindletop SA	Beaumont	TX	9/14/89	3/16/89	6/01/90
	08656	Spindletop Savings Association, FA	Beaumont	TX			
8475	08085	Bedford SA	Bedford	TX		4/06/89	4/20/90
8544	08532	Continental Savings, a FS&LA	Bellaire	TX		3/09/89	8/16/91
7789	06321	San Jacinto SA	Bellaire	TX	12/14/90	11/30/90	9/27/91
	09033	San Jacinto Savings Association, FA	Bellaire	TX			
7827	07951	Citizens Security S&LA	Borger	TX	3/22/91	3/22/91	8/16/91
	09100	Citizens Security Bank, FA	Borger	TX			
8634	05327	First S&LA	Borger	TX	5/18/90	5/18/90	6/28/91
	08848	First Federal Savings Association	Borger	TX			
8635	01574	First SA of Brenham	Brenham	TX	9/21/89	9/21/89	5/25/90
	08668	First FS&LA of Brenham	Brenham	TX			
8509	07460	Golden Triangle S&LA	Bridge City	TX		3/16/89	10/12/90
7814	07648	Amigo S&LA	Brownsville	TX	8/03/90	8/03/90	6/28/91
	08901	Amigo FS&LA	Brownsville	TX			
8481	06865	Southmost S&LA	Brownsville	TX		3/02/89	10/26/90
7882	07880	Burleson County SA	Caldwell	TX	5/31/91	5/31/91	2/28/92
	09234	Burleson County FSA	Caldwell	TX			
8503	06371	Sabine Valley S&LA	Center	TX	12/14/90	3/16/89	5/31/91
	09027	Sabine Valley FSA	Center	TX			
8482	07174	Trinity Valley S&LA	Cleveland	TX		3/09/89	10/06/89
8228	02659	First S&LA of Conroe	Conroe	TX	5/18/90	5/18/90	7/19/91
	08842	First FSA of Conroe	Conroe	TX			
8814	07314	Texasbanc Savings Association	Conroe	TX	2/23/90	2/23/90	8/02/91
	08776	Texasbanc FSB	Conroe	TX			
8662	07676	Fortune Financial a S&L Institution	Copperas Cove	TX	11/30/89	11/30/89	10/19/90
	08724	Fortune Financial FS&LA	Copperas Cove	TX			

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8511	07272	Padre Federal Savings & Loan	Corpus Christi	TX		3/02/89	1/11/91
8510	08020	Golden Circle SA, FSB	Corsicana	TX		4/06/89	8/24/90
7899	08019	Davy Crockett Federal Savings Bank	Crockett	TX	9/13/91	9/13/91	3/06/92
	09421	Davy Crockett Federal SA	Crockett	TX			
8454	06370	Bright Banc SA	Dallas	TX		2/10/89	2/02/90
8624	00053	Metropolitan Financial Savings & Loan	Dallas	TX	8/10/89	8/10/89	6/22/90
	08660	Metropolitan Financial FS&LA	Dallas	TX			
8458	06623	Murray SA	Dallas	TX	5/04/89	4/05/89	6/08/90
	08580	Murray FS&LA	Dallas	TX			
8496	08086	Park Cities Savings Association	Dallas	TX		4/06/89	8/10/89
8280	05603	Southwest SA	Dallas	TX	6/15/90	5/18/90	7/26/91
	08865	Southwest Federal Savings Association	Dallas	TX			
8612	08513	Sunbelt Savings FSB	Dallas	TX	4/26/91	4/26/91	4/10/92
	09164	Sunbelt Federal Savings, FSB	Irving	TX			
8501	07593	Southeastern SA	Dayton	TX		3/09/89	10/26/90
8462	00033	Resource SA	Denison	TX		4/06/89	11/16/90
8627	02310	Denton SA	Denton	TX	8/24/89	8/24/89	6/22/90
	08659	Denton FS&LA	Denton	TX			
8552	06761	Heritagebank SA	Duncanville	TX		4/06/89	4/27/90
7791	06346	Hidalgo S&LA	Edinburg	TX	9/21/90	9/21/90	8/09/91
	08945	Hidalgo FS&LA	Edinburg	TX			
8895	00078	El Paso FS&LA	El Paso	TX	9/07/90	9/07/90	9/20/91
	08922	El Paso Federal Savings Association	El Paso	TX			
7859	08501	Merabank Texas, FSB	El Paso	TX	5/31/91	5/31/91	4/03/92
	09233	New Merabank Texas, FSB	El Paso	TX			
9663	07240	Southwestern S&LA	El Paso	TX	11/30/89	11/30/89	6/14/91
	08703	Southwestern FSA	El Paso	TX			
8650	06869	Surety SA	El Paso	TX	10/19/89	10/19/89	6/07/91
	8681	Surety Federal Savings Association	El Paso	TX			
8816	07387	Remington SA	Elgin	TX	5/25/90	5/25/90	5/30/91
	08812	Remington FS&LA	Elgin	TX			
8478	00017	Bankers S&LA	Galveston	TX		3/09/89	3/16/90
8292	06228	Bannerbank Savings Association	Garland	TX	1/04/90	1/04/90	9/28/90
	08713	Bannerbank FS&LA	Garland	TX			
8636	03842	First Garland Savings Association	Garland	TX	9/21/89	9/21/89	6/22/90
	08667	First Garland FS&LA	Garland	TX			
8637	04113	Certified SA	Georgetown	TX	1/11/90	1/11/90	7/19/91
	08720	Certified Federal Savings Association	Georgetown	TX			
8477	00060	Centennial Savings Bank, FSB	Greenville	TX	7/13/89	4/06/89	3/02/90
	08622	Centennial FS&LA	Greenville	TX			
8586	05364	Hearne B&LA	Hearne	TX	8/17/89	8/17/89	5/25/90
	08649	Hearne B&LA, FA	Hearne	TX			
7862	08499	First Federal Savings Bank of Hempstead	Hempstead	TX	9/14/90	9/14/90	7/26/91
	08921	First Savings Bank of Hempstead, FSB	Hempstead	TX			
8545	07469	General SA	Henderson	TX		3/16/89	6/29/90
8470	06907	Ameriway Savings	Houston	TX		3/09/89	5/11/90
8456	05872	Benjamin Franklin SA	Houston	TX	6/29/89	3/09/89	9/16/91
	08591	Benjamin Franklin FSA	Houston	TX			
8457	07579	Commonwealth SA	Houston	TX	5/25/89	3/09/89	6/21/91
	08550	Commonwealth FSA	Houston	TX			
8596	08222	Cornerstone Savings Association	Houston	TX	7/13/89	7/13/89	5/18/90
	08584	Cornerstone FSA	Houston	TX			
8483	07194	First Capital SA of Texas	Houston	TX		3/09/89	9/22/89
8464	05907	Meritbank SA	Houston	TX		3/16/89	9/14/90
8479	06139	Spring Branch S&LA	Houston	TX		3/09/89	8/31/90
8512	06314	Standard SA	Houston	TX	1/18/90	1/18/90	8/26/91
	08739	Standard FSA	Houston	TX			
8658	02729	Texas Western FS&LA	Houston	TX	11/16/89	11/16/89	8/17/90
	08692	Texas Western FSA	Houston	TX			
8474	07213	Universal SA	Houston	TX	5/24/90	3/09/89	6/22/90
	08831	Universal FSA	Houston	TX			
8455	05749	University SA	Houston	TX	5/25/89	2/14/89	10/13/89
	08578	University Federal SA	Houston	TX			
8484	07734	Village Savings FSB	Houston	TX		3/09/89	9/22/89
8494	07391	Humble S&LA	Humble	TX		3/09/89	9/15/89
8489	07456	Savings of Texas Association	Jacksonville	TX		3/16/89	9/28/90
8495	07482	Deep East Texas SA	Jasper	TX		3/16/89	11/02/90
8473	03190	Jasper FS&LA	Jasper	TX		3/16/89	6/14/91
7806	07258	Atascosa SA	Jourdanton	TX	11/30/90	1/30/90	8/02/91
	09018	Atascosa Federal Savings Bank	Jourdanton	TX			
8638	07018	Karnes County S&LA	Karnes City	TX	1/18/90	1/18/90	12/07/90
	08736	Karnes County FS&LA	Karnes City	TX			
8513	06408	Permian S&LA	Kermit	TX		3/02/89	8/10/90
8597	07492	Guadalupe S&LA	Kerrville	TX	8/17/89	8/17/89	6/08/90
	08657	Guadalupe S&LA, FA	Kerrville	TX			
8502	08336	Federal Savingsbank of the Southwest	Kilgore	TX	7/27/89	7/27/89	6/01/90
	08614	Federal SA of the Southwest	Kilgore	TX			

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8485	07592	Vision Banc SA	Kingsville	TX		3/02/89	12/07/90
8504	06124	Bayshore SA	La Porte	TX	12/14/90	3/09/89	9/20/91
	09036	Bayshore Federal Savings Association	La Porte	TX			
8465	06917	American S&LA of Brazoria	Lake Jackson	TX		3/09/89	9/28/90
8548	06222	Excel Banc SA	Laredo	TX		4/06/89	12/14/90
8640	02607	First FS&LA	Laredo	TX	9/14/89	9/14/89	6/15/90
	08666	First Savings of Laredo, FA	Laredo	TX			
8507	07871	City Savings Association	League City	TX		3/09/89	8/31/90
8499	03094	Liberty County FS&LA	Liberty	TX		3/09/89	7/19/91
8598	07870	Caprock S&LA	Lubbock	TX	8/01/89	8/01/89	9/21/90
	08624	Caprock FS&LA	Lubbock	TX			
8263	03073	First Federal Savings Bank	Lubbock	TX	10/11/91	10/11/91	3/20/92
	09469	First Federal Savings Association	Lubbock	TX			
8253	03493	Marshall FS&LA	Marshall	TX	1/18/90	1/18/90	6/29/90
	08723	Marshall SA, FA	Marshall	TX			
8652	03059	Valley FS&LA	McAllen	TX	10/19/89	10/19/89	6/29/90
	08682	Valley Federal Savings Association	McAllen	TX			
8285	05893	First Bankers Trust & Savings	Midland	TX	6/08/90	6/08/90	5/10/91
	08884	First Bankers T&SA, FA	Midland	TX			
8218	02429	First FS&LA	Nacogdoches	TX	11/30/90	11/30/90	5/31/91
	09015	First FSA of Nacogdoches	Nacogdoches	TX			
8290	06077	Superior Federal Savings Bank	Nacogdoches	TX	8/10/90	8/10/90	7/19/91
	08904	Superior Savings Bank, FSB	Nacogdoches	TX			
8493	07591	Timberland SA	Nacogdoches	TX	12/14/90	3/16/89	8/02/91
	09025	Timberland FSA	Nacogdoches	TX			
8639	08214	Columbia Savings Association	Nassau Bay	TX	12/21/89	12/21/89	9/13/91
	08700	Columbia FSA	Nassau Bay	TX			
7849	08311	Executive Banc Savings	New Braunfels	TX	11/09/90	11/09/90	8/09/91
	08974	Executive Banc SA, FA	New Braunfels	TX			
8249	03281	First FS&LA	New Braunfels	TX	5/25/90	5/25/90	6/07/91
	08830	First Federal Savings, FSA	New Braunfels	TX			
8599	07406	New Braunfels S&LA	New Braunfels	TX	7/27/89	7/27/89	6/01/90
	08607	New Braunfels S&LA, FA	New Braunfels	TX			
8818	07484	Nowlin SA	North Richland Hills	TX	2/23/90	2/23/90	8/16/91
	08777	Nowlin Federal Savings Association	Fort Worth	TX			
8460	06433	Bancplus Savings Association	Pasadena	TX	12/14/90	3/09/89	9/20/91
	09026	Bancplus Federal Savings Association	Houston	TX			
8600	02685	Hallmark Savings Association	Plano	TX	7/27/89	7/27/89	5/16/90
	08597	Hallmark S&LA, FA	Plano	TX			
8587	06871	Plano S&LA	Plano	TX	9/21/89	9/21/89	6/15/90
	08662	Plano S&LA, FA	Plano	TX			
8551	00134	Fidelity S&LA	Port Arthur	TX	10/19/89	3/16/89	11/30/90
	08683	Fidelity Federal Savings Association	Port Arthur	TX			
8466	05647	First South SA	Port Neches	TX	12/14/90	3/15/89	7/12/91
	09038	First South FSA	Port Neches	TX			
8500	02813	Rusk FS&LA	Rusk	TX		3/16/89	6/29/90
8463	06120	Alamo SA of Texas	San Antonio	TX	6/29/89	3/02/89	5/03/91
	08583	Alamo FSA of Texas	San Antonio	TX			
8549	08289	Bexar Savings Association	San Antonio	TX		3/02/89	6/15/90
7847	08227	City S&LA of San Antonio	San Antonio	TX	10/26/90	10/26/90	9/04/91
	08958	City S&LA, FA	San Antonio	TX			
8461	06298	Commerce SA	San Antonio	TX	12/14/90	2/28/89	7/12/91
	09034	Commerce Federal Savings Association	San Antonio	TX			
8863	03792	First FS&LA	San Antonio	TX			1/4/91
8467	07437	First State SA	San Antonio	TX	6/29/89	3/02/89	5/04/90
	08585	First State FSA	San Antonio	TX			
8459	07082	Gill Savings Association	San Antonio	TX		2/07/89	6/15/90
8490	07670	La Hacienda Savings Association	San Antonio	TX		3/02/89	5/04/90
8480	07309	Mission SA of Texas	San Antonio	TX		3/02/89	5/04/90
8601	07507	North American Savings Association	San Antonio	TX	7/27/89	7/27/89	5/22/90
	08594	North American FSA	San Antonio	TX			
8550	01537	San Antonio SA	San Antonio	TX	7/13/89	3/02/89	3/09/90
	08596	San Antonio Savings Association, FA	San Antonio	TX			
8547	07557	Suburban Savings Association	San Antonio	TX		3/02/89	9/14/90
8873	05140	Texas S&LA	San Antonio	TX	4/20/90	4/20/90	5/22/91
	08794	Texas Federal Savings Association	San Antonio	TX			
8678	00026	Travis Savings & Loan	San Antonio	TX	6/29/90	6/29/90	6/21/91
	08866	Travis FS&LA	San Antonio	TX			
8497	07486	First SA of Southeast Texas	Silsbee	TX		3/16/89	11/30/90
7839	08080	Texas Commercial SA	Sulphur Springs	TX	9/21/90	9/21/90	6/14/91
	08946	Texas Commercial FSA	Sulphur Springs	TX			
8588	05429	Taylorbanc SA	Taylor	TX	8/17/89	8/17/89	6/22/90
	08650	Taylorbanc FS&LA	Taylor	TX			
7741	03349	First FS&LA	Temple	TX	8/24/90	8/24/90	9/06/91
	08905	First S&LA, FA	Temple	TX			
8468	08415	Security Savings Association, FSA	Texarkana	TX	9/28/89	3/16/89	12/07/90
	08671	Security Federal Savings Association	Texarkana	TX			

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8486	07439	First Equity SA	Tomball	TX	8/17/89	3/09/89	5/11/90
	08635	First Equity Savings Association, FA	Tomball	TX			
8589	01092	East Texas S&LA	Tyler	TX	9/21/89	9/21/89	6/08/90
	08661	East Texas S&LA, FA	Tyler	TX			
8819	07510	First Southwest S&LA	Tyler	TX	11/30/90	11/30/90	8/23/91
	09016	First Southwest FS&LA	Tyler	TX			
8619	07722	Uvalde S&LA	Uvalde	TX	1/26/90	1/26/90	10/19/90
	08733	Uvalde FS&LA	Uvalde	TX			
8556	03359	Victoria Savings Association	Victoria	TX	6/29/89	6/29/89	10/25/91
	08587	Victoria Savings Association FSA	Victoria	TX			
8469	05347	Central Texas S&LA	Waco	TX		4/06/89	11/02/90
8590	00453	First FS&LA	Waco	TX	7/13/89	7/13/89	6/15/90
	08599	First S&LA, FA	Waco	TX			
8221	02482	Mutual B&LA	Weatherford	TX	6/01/90	6/01/90	7/12/91
	08835	Mutual S&LA, FA	Weatherford	TX			
8251	03400	First FS&LA	Wichita Falls	TX	3/16/90	3/16/90	6/07/91
	08791	First Federal Savings Association	Wichita Falls	TX			
8216	02363	North Texas FS&LA	Wichita Falls	TX	7/13/90	7/13/90	5/31/91
	08891	North Texas FSA	Wichita Falls	TX			
8508	06632	Southeast Texas S&LA	Woodville	TX	12/14/90	3/16/89	6/28/91
	09035	Southeast Texas FSA	Woodville	TX			
8523	08537	Mountainwest S&LA, A FS&LA	Ogden	UT		2/17/89	5/25/90
8514	01894	American S&LA, A Federal Association	Salt Lake City	UT	9/07/89	2/17/89	6/08/90
	08665	American Savings, A FS & LA	Salt Lake City	UT			
8515	01827	Deseret FS&LA	Salt Lake City	UT	10/05/89	2/10/89	5/25/90
	08677	Deseret S&LA, FA	Salt Lake City	UT			
8883	07772	Home Savings Bank	Salt Lake City	UT	7/05/90	7/05/90	2/28/92
	08849	Home Savings Bank, FSB	Salt Lake City	UT			
8854	07367	Williamsburg Savings Bank	Salt Lake City	UT	1/26/90	1/26/90	9/14/90
	08727	Williamsburg FSB	Salt Lake City	UT			
7961	08557	Federal Savings Bank of Virginia	Falls Church	VA	4/10/92	4/10/92	
	09883	Federal SA of Virginia	Falls Church	VA			
8591	01470	Peoples S&LA, FA	Hampton	VA		6/29/89	5/18/90
7952	06995	Commonwealth Savings Bank of Virginia	Manassas	VA	4/03/92	4/03/92	
	09882	Commonwealth FSB	Manassas	VA			
7920	06579	Perpetual SB	McLean	VA			1/10/92
8517	07567	Community FS&LA	Newport News	VA		3/30/89	5/18/90
8672	01179	Atlantic Permanent Savings Bank FSB	Norfolk	VA	12/08/89	12/08/89	7/12/91
	08711	Atlantic Permanent FSB	Norfolk	VA			
7773	05301	Berkley Federal Savings Bank	Norfolk	VA	5/03/91	5/03/91	3/20/92
	09173	Sentry Federal Savings Association	Norfolk	VA			
7945	08207	Vista Federal Savings Bank	Reston	VA	2/28/92	2/28/92	
	09699	Vista Federal Savings Association	Reston	VA			
7807	07307	Coreast Savings Bank, FSB	Richmond	VA	2/01/91	2/01/91	3/06/92
	09053	Coreast Federal Savings Bank	Roanoke	VA			
7805	07103	Heritage Savings Bank, FSB	Richmond	VA	10/19/90	10/19/90	7/05/91
	08972	Heritage Federal Savings Bank	Richmond	VA			
7917	07385	Investors Savings Bank	Richmond	VA	12/13/91	12/13/91	
	09570	Investors Federal Savings Bank	Richmond	VA			
8592	07337	Seasons Savings Bank, FSB	Richmond	VA	10/19/89	10/19/89	9/28/90
	08686	Seasons Federal Savings Bank	Richmond	VA			
8284	05854	Security FS & LA	Richmond	VA	3/02/90	3/02/90	9/28/90
	08768	Security Federal Savings Association	Richmond	VA			
7808	07359	Dominion FS&LA	Tysons Corner	VA	1/25/91	1/25/91	3/20/92
	09048	Trustbank Federal Savings Bank	Tysons Corner	VA			
7801	06980	United Savings Bank	Vienna	VA	7/31/90	7/31/90	9/20/91
	08918	United Federal Savings Bank	Vienna	VA			
8558	06861	Gibraltar Savings, FA	Bellevue	WA	10/31/89	3/31/89	6/29/90
	08688	Gibraltar Savings Bank, FSB	Seattle	WA			
7809	07379	Family S&LA	Seattle	WA	2/08/91	2/08/91	7/19/91
	09058	Family S&LA, FA	Seattle	WA			
8857	01690	Frontier FS&LA	Walla Walla	WA	2/23/90	2/23/90	6/22/90
	08773	Frontier FSA	Walla Walla	WA			
7765	03236	Monycor Savings Bank, FSB	Barron	WI	7/12/91	7/12/91	3/13/92
	09319	Monycor Federal Savings Bank	Barron	WI			
8520	03253	Durand FS&LA	Durand	WI		3/30/89	5/25/90
8519	02410	Community S&LA	Fond Du Lac	WI		2/17/89	2/09/90
8697	01058	First FS&LA	Bluefield	WV	2/23/90	2/23/90	11/09/90
	08767	First Federal SA of Bluefield	Bluefield	WV			
7918	01061	Evergreen Federal Savings Bank	Charleston	WV	9/13/91	9/13/91	
	09420	Evergreen Federal S&LA	Charleston	WV			
8279	05476	First Standard Savings FA	Fairmont	WV	2/23/90	2/23/90	11/02/90
	08766	First Standard Federal SA	Fairmont	WV			
8899	07318	Shenandoah Federal Savings Bank	Martinsburg	WV	5/08/92	5/08/92	
	09975	Shenandoah FSA	Martinsburg	WV			
8669	01344	Provident FS&LA	Casper	WY	2/23/90	2/23/90	8/17/90
	08774	Provident SA, FA	Casper	WY			

LIST OF INSTITUTIONS—BY STATE/CITY, AUGUST 9, 1989 THRU JUNE 30, 1992—Continued

Bank No.	Docket before/after	Institution name before pass-through, institution name after pass-through	City before pass-through, city after pass-through	State before/after	Date of pass-thru	Conserv. date	Resolution date
8668	07238	First Guaranty S&LA	Gillette	WY	11/30/89	11/30/89	6/15/90
	08725	First Federal Savings Bank	Diamondville	WY			
8255	03556	Westland FS&LA	Rawlins	WY			7/26/91
8256	03557	Sweetwater FS&LA	Rock Springs	WY			8/22/90

Dated at Washington, D.C., this 25th day of August, 1992.

Resolution Trust Corporation.

John M. Buckley, Jr.,

Secretary.

[FR Doc. 92-20954 Filed 8-31-92; 8:45 am]

BILLING CODE 6714-01-M

SECURITIES AND EXCHANGE COMMISSION

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Midwest Stock Exchange, Incorporated

August 26, 1992.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to Section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

Discount Auto Parts, Inc.

Common Stock, \$.01 Par Value (File No. 7-8945)

LTC Properties, Inc.

Common Stock, \$.01 Par Value (File No. 7-8946)

Sunbeam Oster Company, Inc.

Common Stock, \$.01 Par Value (File No. 7-8947)

Blackrock 2001 Term Trust, Inc.

Common Stock, \$.01 Par Value (file No. 7-8948)

Provident Life & Accident Insurance

Company of America
Class A Common Stock, \$.01 Par Value
(File No. 7-8949)

Provident Life & Accident Insurance

Company of America
Class B Common Stock, \$.01 Par Value (File No. 7-8950)

Washington Energy Company

Common Stock, \$.50 Par Value (File No. 7-8951)

Indresco, Inc.

Common Stock, \$.25 Par Value (File No. 7-8952)

Pacificorp

\$1.98 Series 1992 Preferred Stock, No Par Value (File No. 7-8953)

These securities are listed and registered on one or more other national securities exchange and is reported in

the consolidated transaction reporting system.

Interested persons are invited to submit on or before September 17, 1992, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20459. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such application is consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,
Secretary.

[FR Doc. 92-21003 Filed 8-31-92; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Pacific Stock Exchange, Incorporated

August 26, 1992.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

Sunbeam Oster, Inc.

Common Stock, \$.01 Par Value (File No. 7-8954)

Universal Foods Corporation

Common Stock, \$.10 Par Value (File No. 7-8955)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before September 17, 1992,

written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,
Secretary.

[FR Doc. 92-21005 Filed 8-31-92; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Philadelphia Stock Exchange, Inc.; Application for Unlisted Trading Privileges in Over-the-Counter Issues

August 26, 1992.

On August 21, 1992, the Philadelphia Stock Exchange, Inc. submitted an application for unlisted trading privileges ("UTP") pursuant to section 12(f)(1)(C) of the Securities Exchange Act of 1934 ("Act") in the following over-the-counter ("OTC") securities, i.e., securities not registered under Section 12(b) of the Act.

File no.	Symbol	Issuer
7-8939	CMCSA	Comcast Corporation, Common Stock \$1. Par Value.
7-8940	GIBG	Gibson Greetings, Inc., Common Stock \$.01, Par Value.
7-8941	LINB	Lin Broadcasting Corporation, Common Stock \$.01, Par Value.
7-8942	MCCRK	McCormick & Company Inc., Common Stock, No Par Value.

File no.	Symbol	Issuer
7-8943.....	PCTL	Picturetel Corporation, Common Stock \$0.01, Par Value.
7-8944.....	STBK	State Street Boston Corp., Common Stock \$1, Par Value.

Comments

Interested persons are invited to submit, on or before September 16, 1992, written comments, data, views and arguments concerning this application. Persons desiring to make written comments should file three copies with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Commentators are asked to address whether they believe the requested grant of UTP would be consistent with Section 12(f)(1), which requires that, in considering an application for extension of UTP in OTC securities, the Commission consider, among other matters, the public trading activity in such security, the character of such trading, the impact of such extension on the existing markets for such securities, and the desirability of removing impediments to and the progress that has been made toward the development of a National Market System.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 92-21002 Filed 8-31-92; 8:45 am]

BILLING CODE 8010-01-M

**Self-Regulatory Organizations;
Applications for Unlisted Trading
Privileges and of Opportunity for
Hearing; Philadelphia Stock Exchange,
Incorporated**

August 26, 1992.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

- First Boston Strategic Income Fund
Common Stock, \$0.01 Par Value (File No. 7-8956)
- Sunbeam Oster Company, Inc.
Common Stock, \$0.01 Par Value (File No. 7-8957)
- Pudget Sound Power & Light Company
Pfd Stock Cum. 7% Series, \$25 Par Value
(File No. 7-8958)
- Discount Auto Parts, Inc.

Common Stock, \$0.01 Par Value (File No. 7-8959)

Provident Life and Accident Insurance
Company of America
Class A Common Stock, \$1.00 Par Value
(File No. 7-8960)

Provident Life and Accident Insurance
Company of America
Class B Common Stock, \$1.00 Par Value
(File No. 7-8961)

Blackrock 2001 Term Trust, Inc.
Common Stock, \$0.01 Par Value (File No. 7-8962)

LTC Properties, Inc.
Common Stock, \$0.01 Par Value (File No. 7-8963)

Washington Energy Company
Common Stock, \$0.01 Par Value (File No. 7-8964)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before September 17, 1992, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,

Secretary.

[FR Doc. 92-21004 Filed 8-31-92; 8:45 am]

BILLING CODE 8010-01-M

[Rel. No. IC-18893; 812-7763]

Keene Corporation; Application

August 12, 1992.

Correction

In FR Document No. 92-19820 beginning on page 37861 for Thursday, August 20, 1992, the release number for File No. 812-7763 was incorrectly stated as IC-18894. The correct release number is IC-18893.

Dated: August 26, 1992.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 92-20940 Filed 8-31-92; 8:45 am]

BILLING CODE 8010-01-M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Environmental Impact Statement; Elk County, Pennsylvania

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of Intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an Environmental Impact Statement will be prepared for a proposed highway project in Elk County, Pennsylvania.

FOR FURTHER INFORMATION CONTACT:

John A. Gerner, District Engineer, Federal Highway Administration, 228 Walnut Street, P.O. Box 1086, Harrisburg, Pennsylvania 17108-1086, Telephone: (717) 782-3411 or James R. Bathurst, P.E., Design Services Engineer, Pennsylvania Department of Transportation, 1924-30 Daisy Street, Clearfield, Pennsylvania 16830, Telephone (814) 765-0437.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the Pennsylvania Department of Transportation (PennDOT), will prepare an Environmental Impact Statement and an Engineering Basis Report for a section of U.S. Route 219 in Elk County, Pennsylvania. Located in Johnsonburg, Pennsylvania, this two mile project will improve the safety and relieve traffic congestion on this section of U.S. Route 219. The northern terminus and study area limits will be the existing two lanes of U.S. Route 219 just north of Johnsonburg. The southern terminus and study area limits will be approximately one-half mile south of Pennsylvania Route 255.

It is anticipated that at least five alternatives will be evaluated during the course of the study. Based on existing and projected traffic volumes, all build alternatives will require a two-lane facility to accommodate the traffic volumes. The alternates under consideration are: upgrading the existing facility, transportation system management, two alternatives on new location west of existing U.S. Route 219, and the "NO BUILD" alternate. Mass transit and multi-modal design will not be considered on this project.

A two phased approach will be used to develop the Environmental Impact Statement. The initial phase of this project will be the development of the need for the project. A Plan of study for the Environmental Impact Statement and Engineering Basis Report will be prepared and circulated to resourced

agencies for the alternatives under consideration.

The Scoping Process for the Environmental Impact Statement begins with the circulation of the Plan of Study. Following the comment period, a Scoping Field View and Meeting will be scheduled at the site of the project to discuss comments received and view the area to be studied. As a result of the Scoping Field View and meeting, the Plan of Study will be revised to incorporate any changes required and a revised Plan of Study will be distributed.

The second phase of the study process will consider detailed environmental and engineering studies on the alternatives that meet the project need. The results on these studies will be presented in the Environmental Impact Statement. From this analysis, a preferred alternative will be identified which best meets the project need and satisfies the environmental, socio-economic, and engineering evaluations and public input.

An active public participation program will be pursued during the project. At the beginning of the study an advertisement will be placed in local newspapers and the Pennsylvania Bulletin informing the public and public agencies of the study and soliciting names of individuals, organizations and agencies interested in participating in the study. A Citizens Advisory Committee will be formed and will meet regularly during the study. This comment will provide liaison between the Commonwealth of Pennsylvania and the local citizens, and participate in all aspects of the study. Public meeting will be held throughout the study to gather input to be used in the study and distribute information on the study. A Public Hearing will be held at the conclusion of the study to solicit comments from the public on alternatives presented. The Draft Environmental Impact Statement will be available for public and agency review and comment prior to the public hearing. Should it become apparent during the development of the project that an alternative emerges which causes no public controversy on environmental grounds and causes no significant impacts, a revised notice of intent will be published, advising of intent to perform an Environmental Assessment/ Finding of No Significant Impact.

To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments and suggestions are invited from all interested parties. Comments or questions concerning this proposed action and the EIS should be

directed to the FHWA at the address provided above.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Research, Planning, and Construction. The regulations implementing Executive Order 12372 regarding intergovernment consultation on Federal programs and activities apply to this program.)

Dated: August 14, 1992.

George Hannon,

Asst. Division Administrator.

[FR Doc. 92-20959 Filed 8-31-92; 8:45 am]

BILLING CODE 4910-22-M

DEPARTMENT OF THE TREASURY

Public Information Collection Requirements Submitted to OMB for Review

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Public Law 96-511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 3171 Treasury Annex, 1500 Pennsylvania Avenue, NW., Washington, DC 20220.

Special Request: The Department is requesting approval of the Internal Revenue Service sponsored survey below by August 28, 1992. To allow public comment and review, the survey and its instructions is attached to this notice.

Internal Revenue Service

OMB Number: New.

Form Number: None.

Type of Review: New collection.

Title: Child Care Survey.

Description: The Survey was developed by a doctoral student working on her PhD. dissertation at the University of South Florida (USF) to gather research data on the child care arrangements of single parents and two-income parents and on how these arrangements change over a 3 year (1988-1990) period. Respondents will mail questionnaires directly to the USF student for tabulation and analysis.

Respondents: Individuals or household.

Estimated Number of Respondents: 900.

Estimated Burden Hours Per

Respondent: 16 minutes.

Frequency of Response: Other (one-time survey).

Estimated Total Reporting Burden: 234 hours.

Clearance Officer: Garrick Shear (202) 535-4297, Internal Revenue Service, Room 5571, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Milo Sunderhauf (202) 395-6880, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503.

Louis K. Holland,

Departmental Reports, Management Officer.

Attachment I

Date:

Dear Parent: In a few days, you will be receiving a questionnaire from Karen Lanese, a doctoral student working on her Ph.D at the University of South Florida. Karen is working on her dissertation and is interested in the use of child care services and how child care arrangements change over time. Your help in completing this questionnaire would be most appreciated.

In an effort to gather responses from a broad group of parents, we asked the Internal Revenue Service to identify a group of taxpayers who had claimed the child care credit in 1988 and to allow us to send a questionnaire to these people. As the Internal Revenue Service is required to keep all information regarding taxpayers private, they agreed to send the questionnaires for us. The Internal Revenue Service has identified approximately 900 taxpayers for this purpose. All responses to the questionnaires are to be completely anonymous and no individual level information will be made available to the Internal Revenue Service. Summary statistical data from the survey is scheduled to be presented, along with other tax studies, at an IRS Tax Research Conference this November in Washington, DC. The survey findings may result in the IRS considering changes to the Dependent Care Credit form and instructions, and possibly in suggested legislative revisions to improve the dependent care credit.

If you would like more information regarding how you were selected to receive the questionnaire, please contact John Szilagyi at the Internal Revenue Service's Research Division (202) 874-0608. If you would like more information regarding Karen's research project, please contact me at (813) 974-4186.

Thank you for your participation in this project. A high level of responses to this questionnaire will allow Karen to draw meaningful conclusions for her project.

Sincerely,

Cherie J. O'Neil,
Quinn Professor.

Attachment II

Date:

Dear Parent: I am a doctoral student at the University of South Florida. In relation to research I am conducting for my dissertation, I would appreciate it if you would take a few minutes to complete the enclosed questionnaire and return it in the postage

paid envelope. Total anonymity of your responses is guaranteed.

I am conducting research on the child care arrangements of single parents and two-income parents, and how child care arrangements change over time. Please try to recall, what child care arrangement you made over a three (3) year period from 1988 through 1990. I am interested in the amount you spent for child care, the number of children you had to arrange child care for and the types of child care provider(s) you used. If you did not have any children under the age of 15 living in your home, please answer only question #1.

Thank you for your cooperation.

Sincerely,

Karen Lanese,
Ph.D Candidate.

Child Care Survey

If yes or no answer is required, please circle the appropriate answer.

1. Did you have one or more children under the age of 15 living in your home any time during the following years?

1988 Yes / No

1989 Yes / No

1990 Yes / No

If you answered NO to all three years, do not answer the remainder of the questionnaire. Please return the questionnaire in the postage paid return envelope.

2. Please indicate in each of the columns the answer that best applies to your family during the years indicated.

If a series of potential answers is provided, please place the number that corresponds to your situation in the spaces provided. If you select 'other', please explain in the comments section provided on the last page of the questionnaire.

	1988	1989	1990
A. Marital Status:			
1. Married			
2. Single or divorced			
If married, answer for both mother and father (B. and C.).			
If single or divorced, answer only for yourself (B. and C.).			
B. Earned Income of Father: The dollar amount of earned income in each year (wages, salaries, self-employment income).....	\$.....	\$.....	\$.....
Average hours per week worked outside the home.....			
C. Earned Income of Mother: The dollar amount of earned income in each year (wages, salaries, self-employment income).....	\$.....	\$.....	\$.....
Average hours per week worked outside the home.....			
D. If a single parent, did you receive alimony or child support payments in any of the three years?	Yes / No	Yes / No	Yes / No
E. Total Nonwage Income: Amount of household savings income (interest and dividends) earned			
1. \$0-99			
2. 100-199			
3. 200-399			
4. 400-799			
5. 800-999	\$.....	\$.....	\$.....
6. Over-1,000			
F. Number of Children: (age based on birthday in the year for each column)			
number of newborns to 2 year olds			
number of 3 and 4 year olds			
number of 5 year olds			
number of 6 year olds			
number of 7 to 12 year olds			
number of 13 to 14 year olds			
number of children at home (or full-time students) above 14 years old			
G. Who cared for the children while you worked? (outside regular school hours) Enter as many numbers as apply for each year.			
1. other parent			
2. family relative (unpaid)			
3. self-care (latch-key after-school)			
4. paid care in child's home			
5. paid care in baby sitter's home			
6. day care center			
7. extended day program at child's school			
8. other _____			
H. If paid care was provided in your home, did you:			
1. pay social security taxes on behalf of your babysitter?			
2. withhold social security from your babysitter's pay?			
3. did not do either 1. or 2. above			
I. If paid care was used, did you take the child care credit on your tax return?	Yes / No	Yes / No	Yes / No
J. If paid care was used and you did not take the credit, what was your reason(s) for not taking the credit?			
1. babysitter did not want you to			
2. babysitter would not give you their			
3. forms were too complicated			
4. did not keep good records of expenses			
5. employer provided on-site child care benefits			
6. child care expenses aid from employer salary reduction plan			
7. other _____?			
K. If paid care was used, how much was spent on child care each year?.....	\$.....	\$.....	\$.....
L. If paid care was used, for how many children was care provided?.....			

	1988	1989	1990
M. If you stopped using paid child care in 1988, 1989, or 1990, what was the reason?			
1. one parent able to care for child			
2. child old enough to care for self			
3. relatives caring for child (unpaid)			
4. employer provided child care assistance plan			
5. other _____			
N. Do you own your own home?	Yes / No	Yes / No	Yes / No
O. Did you use a paid preparer for the preparation of your tax return?	Yes / No	Yes / No	Yes / No
If yes, how much did you pay per year?	\$ _____	\$ _____	\$ _____
P. Did you itemize your deductions?	Yes / No	Yes / No	Yes / No

	Father	Mother
Q. Education: level of education of each parent:		
1. did not graduate high school		
2. high school		
3. two-year college		
4. four-year college		
5. graduate/professional education		
R. Are you self-employed?	Yes / No	Yes / No
S. Age: please give the current age of each parent.		
T. Occupation: please specify for each parent:		
Father		
Mother		

Comments: _____

the questionnaires, ensuring the confidentiality of your responses.

Thank you for your participation in this project. A high level of responses to this study is necessary for Karen to draw meaningful conclusions for her project.

Sincerely,
Cherie J. O'Neil,
Quinn Professor.

Attachment V

Post Card

Front Side: IRS LOIS AVENUE RETURN ADDRESS

Back Side: Identifying Number, OMB No. 1545-

Please Check One:

_____ I completed the questionnaire and have mailed it.

_____ I will complete the questionnaire and mail it within a few days.

_____ I have misplaced the questionnaire, please send me another.

_____ I do not wish to participate in this study.

Attachment VI

SCHOOL OF ACCOUNTANCY
COLLEGE OF BUSINESS
ADMINISTRATION
UNIVERSITY OF SOUTH FLORIDA
2203 NORTH LOIS AVENUE
TAMPA, FL 33607-2356

This is the IRS Tampa POD street address (so undelivered mail will come back to IRS)

Out going envelope to taxpayers using mail labels for KCSC sample

Attachment VII

School of Accountancy
BSN 3403
14-02-000-00
Tampa, FL 33620-5500

Return envelope for taxpayers to mail back USF questionnaire

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NUMBER 2039
TAMPA FL
POSTAGE WILL BE PAID BY ADDRESSEE
UNIVERSITY OF SOUTH FLORIDA
4202 E FOWLER AVE
TAMPA FL 33620-9989

[FR Doc. 92-20141 Filed 8-31-92; 8:45 am]

BILLING CODE 4830-01-M

Office of Thrift Supervision

[No. 92-294]

General Valuation Allowances

AGENCY: Office of Thrift Supervision, Treasury.

ACTION: Request for comment.

SUMMARY: The Office of Thrift Supervision (OTS) is today publishing for comment a description of proposed revisions to its guidance to savings associations and its examination staff regarding the appropriate levels of general valuation allowances (GVAs) savings associations should maintain. Associations are required to maintain GVAs that are sufficient to absorb probable losses not yet identified in their portfolios. An association's management has the primary responsibility for the assessment of the adequacy of general allowances. The role of the examiners is to ensure that associations have thoroughly documented their process for determining the level of the allowances, including analysis of all significant factors.

The proposed policy directs examiners to rely on management's estimates of adequate GVAs if the association's process for determining adequate allowances is sound. To guide examiners in evaluating the reasonableness of an association's allowance levels and in reviewing associations that do not maintain adequate policies, the proposed guidelines set forth quantitative benchmarks as a starting point for the determination of appropriate levels of GVAs. The guidelines also set forth additional quantitative and qualitative factors for analysis in determining the appropriate adjustments to the benchmark amounts for the specific association.

DATES: Comments requested must be received on or before October 1, 1992.

ADDRESSES: Send comments to: Director, Information Services, Office of Public Affairs, Office of Thrift Supervision, 1700 G Street, NW.,

DATE:

Dear Parent: A few days ago you received a questionnaire from Karen Lanese, a doctoral student from the University of South Florida. In order to ensure a high level of response to her questionnaire, we would appreciate your answering the questions on the enclosed post card and returning it. Each post card is numbered so that we may account for all participants in the survey. No such identifying number appears on any of

Washington, DC 20552, Attention: Docket No. [92-294]. These submissions may be hand delivered to 1700 G Street, NW., from 9 a.m. to 5 p.m. on business days, they may be sent by facsimile transmission to FAX Number (202) 906-7753 or (202) 906-5755. Submissions must be received by 5 p.m. on the day they are due in order to be considered by the OTS. Late-filed, misaddressed, or misidentified submissions will not be considered. Comments will be available for public inspection at 1776 G Street, NW., Street Level.

FOR FURTHER INFORMATION CONTACT:

John C. Price, Jr., Deputy Assistant Director for Policy, (202) 906-5745; Robert J. Fishman, Program Manager, (202) 906-5672; William J. Magrini, Project Manager, (202) 906-5744; or Dorene Cadoff, Attorney, (202) 906-7268; Regulations, Legislation and Opinions Division; Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

A. Current GVA Policy

The OTS's current policy, which is set forth at 12 CFR 563.160, 563.172 and 571.26 (1992) and in the Thrift Activities Handbook at section 261 (and the policy followed by the OTS's predecessor, the Federal Home Loan Bank Board), requires savings associations to classify their assets on a regular basis and to establish prudent GVAs for loan losses sufficient to absorb estimated losses inherent in the portfolio.

Valuation allowances as defined in the above regulations may include both specific valuation allowances and general valuation allowances. Specific valuation allowances are established in lieu of charge-offs for probable identified losses attributable to specific assets. GVAs are established to absorb probable losses that have not been identified but that are inherent in the portfolio. This notice deals exclusively with GVAs.

GVAs, in general, address two different concerns: (1) Poor credit quality at origination or deterioration in credit quality after origination or purchase, a concern that applies to classified assets and some assets subject to Special Mention; and (2) the need to protect against probable losses inherent in the portfolio from unidentified asset weaknesses, a concern that applies to all assets, including Pass assets and unreviewed assets. The appropriate level of GVAs is determined differently for these two concerns.

GVAs should be established based upon an analysis of the portfolio that includes: (1) A review of the assets and the determination of the likelihood of loss within the portfolio; (2) the historical loss experience for assets and pools and assets of similar quality and type; and (3) other qualitative factors.

Current OTS guidance requires that an association's management develop a reliable loss analysis methodology to establish and maintain adequate GVAs.¹ Through examinations, OTS evaluates the adequacy of an association's internal asset review function, including its loss analysis methodologies and procedures. As part of its evaluation of an association's GVA adequacy, the OTS evaluates whether management's process considers appropriate quantitative and qualitative factors. These factors are discussed in the November 7, 1991 "Interagency Policy Statement on the Review and Classification of Commercial Real Estate Loans."²

The only specific quantitative guidance the OTS currently gives is that, at a minimum, GVAs should be maintained at a level that correlates with the association's typical average annual loss experience over at least the last three calendar years, unless a higher level is warranted based on current conditions and trends.

Management of savings associations and OTS examination staff have requested better guidance concerning the appropriate level of GVAs an association should maintain. This proposed guidance is intended to provide all regulatory personnel, lending institutions and other interested parties with a clearer understanding of the OTS's policy regarding GVAs and should help to ensure that associations maintain GVAs at prudent levels that contribute to their safe and sound operations.

B. Proposed OTS Policy on GVAs

1. General Policy

Associations must maintain GVAs that are adequate to absorb probable

losses in their portfolios that are not clearly attributable to specific loans. An association's management is responsible for maintaining an effective asset review system and controls that identify, monitor and address asset quality problems in an accurate and timely manner. An association must also adequately document its process for evaluating and determining the level of allowance, including its analysis of all significant factors.

The association must analyze its entire portfolio when evaluating the adequacy of its GVAs. Generally, however, it is not practical or necessary for associations to individually review smaller classified or unclassified assets. Associations may provide for such assets as part of a pool of assets based on historical loss experience, adjusted for current economic conditions and trends. OTS encourages associations to segment their portfolios into components that have similar characteristics, such as risk exposure, past due status, type of loan, industry or collateral.

2. Examiner Guidelines

The responsibility for the assessment of the adequacy of GVAs lies principally with the association's management. The role of examiners is to ensure that management's judgment and analytical approach are sound, the analysis is adequately documented, and all significant factors have been considered. Examiners will evaluate the methodology and process that management has followed to evaluate the adequacy of the GVAs in order to assure that all of the relevant factors affecting the collectability of the portfolio have been appropriately considered. The review will focus on the reasonableness of the GVAs in light of these factors and the quality of the association's systems and management in identifying, monitoring and addressing asset quality problems.

Examiners will rely on management's evaluation of the adequacy of the GVAs if the association's process is sound, based on reliable information, consistently applied and well-documented.

Examiners should utilize the procedures described below to evaluate the reasonableness of an association's GVA level. For associations that do not maintain adequate policies, procedures and systems for establishing appropriate GVA levels, examiners should use the process described below to calculate a prudent level of GVAs.

(a) *Classified assets and assets subject to special mention.* GVAs for

¹ One tool that can be used to assess the appropriate level of allowance would be a "migration-to-loss" tracking system. Such analysis involves the maintenance by savings associations of sufficient information for management and examiners to closely track assets over time to determine the amount of unreviewed, Pass, Special Mention, Substandard, and Doubtful assets that eventually become Loss.

² These factors include: (1) The establishment of prudent written lending policies, loan administration procedures, and credit risk control procedures; (2) the borrower's willingness and capacity to repay the debt; and (3) the income-producing capacity of collateral that supports a loan.

classified assets and assets subject to Special Mention,³ should generally fall within the ranges listed below:

- 0% to 5% of assets subject to Special Mention.
- 5% to 25% of assets classified Substandard.
- 40% to 60% of assets classified Doubtful.

Classification reflects a judgment that the risk of loss on an asset is greater than normal. When estimating the overall loss exposure from classified assets, a number of factors must be considered, including the borrower's overall financial condition, resources, payment record, and other relevant characteristics; the prospects for support from any financially responsible guarantors; and, if appropriate, the value of the collateral.

The actual percentage used should be based on specific circumstances that pertain to the criticized asset and the association. In general, examiners should begin at the midpoint of the range and move higher or lower along the range depending on whether the likelihood of loss is greater or smaller than that amount. Examiners should review the factors listed in subsection 2 (c), below, to determine the appropriate percentage to use for each of the Special Mention, Substandard and Doubtful asset classifications.

For example, assets (or pools of assets) subject to Special Mention would be subject to the higher end of the percentage range if the rating was due to credit quality deterioration (such as delinquency status). The lower end of the range would be appropriate if the rating was based on non-credit quality problems, such as inadequate documentation in loan files. (For Special Mention assets, GVAs should, in no case, be less than the amount required

for similar Pass and unreviewed assets, discussed below.)

Similarly, assets classified as Substandard would be subject to the lower end of the range if, for example, they were collateralized and there was a history of relatively low losses on such assets (such as single family home mortgage loans).

In addition, the association's historical loss experience on classified assets is an important factor. Examiners should consider whether Special Mention, Substandard and Doubtful assets improve or deteriorate over time and the level of losses that are ultimately experienced on criticized assets.

The quality of the association's management, particularly in the workout area, is usually quite important in the determination of the appropriate percentage. Associations with strong troubled loan and real estate workout departments often experience smaller losses on troubled assets and therefore would require lower GVAs.

Allowances outside of these ranges may also be used, if supported by careful analysis and appropriate documentation.

(b) *Pass and unreviewed assets.* GVAs for Pass and unreviewed assets should generally equal expected net charge-offs during the next year. These should normally be based on the level of annual net charge-offs experienced by the association over the previous 3 to 5 years on similar assets, adjusted for current economic conditions and trends.⁴

The association's net charge-off experience should be the starting point for the assessment of the adequacy of allowances. This allowance level would then be adjusted for qualitative factors, outlined below. For example, associations in areas of worsening economic conditions and trends should maintain commensurately higher levels of allowances than would be indicated by the association's average charge-off experience over the previous 3 to 5 years. Similarly, improving economic conditions may warrant a downward adjustment of charge off experience.

(c) *Factors for determining appropriate GVA levels.* For both

criticized and Pass/unreviewed assets, associations and examiners should consider the quality of the following factors in determining appropriate GVA levels:

- Management;
- Written policies of the association, including the effects of any changes in policies and procedures (including those for collection, charge off and recovery);
- Underwriting standards;
- Board of Directors oversight;
- Internal Asset Review function;
- Management risk identification systems;
- Internal controls; and,
- An assessment of whether personnel are adequately implementing the association's written policies.

The items listed below should also be taken into consideration:

- Economic conditions and trends;
- Asset concentrations;
- Level and trend of delinquencies and nonaccruals;
- Level and trend of Troubled Debt Restructurings and modifications;
- Level and trend of repossessed assets;
- Historical collection experience; and,
- Loss levels and trends.

Judgment must be used in the assessment of the relative importance of the above factors. While the analysis of the appropriate GVAs for each savings association is unique, each of the factors listed above is likely to be relevant in determining the appropriate level of GVAs.

3. Other Considerations

In addition to the guidance outlined above, associations and examiners should factor into their determination of appropriate levels of GVAs the fact that asset classification and loss estimation processes are not precise. This factor should be addressed: (1) In the selection of the appropriate percentage of classified and Special Mention assets to use for allowance purposes, and (2) in any adjustment made to an association's historical charge-off experience to determine appropriate allowance levels for Pass and unreviewed assets.

Associations must maintain appropriate levels of allowances at all times. This means that examiners should confirm that once associations have determined the appropriate level of GVAs, they record those allowances promptly, to ensure that their books accurately reflect recoverable asset values.

³ Special Mention assets are those assets that do not currently expose a savings association to a sufficient degree of risk to warrant classification, but that have a potential weakness or pose an unwarranted financial risk that, if not corrected, could weaken the asset and increase risk in the future. Substandard assets have a well-defined weakness and are inadequately protected by the current net worth and paying capacity of the obligor or of the collateral pledged; they are characterized by the distinct possibility that the savings associations will sustain some loss if the deficiencies are not corrected. Doubtful assets have all the weaknesses of Substandard assets with the added characteristic that the weaknesses make collection or liquidation in full highly questionable and improbable. Substandard assets, Doubtful assets and Loss assets are collectively referred to as "classified assets." Classified assets and assets subject to Special Mention are collectively referred to as "criticized assets." Pass assets are those that have been specifically reviewed and found to have no deficiencies that warrant an adverse classification. Unreviewed assets are those that have not been reviewed.

⁴ For example, if an association has historically experienced annual charge-offs of 5 basis points on single family home mortgage loans and it currently has a non-criticized single family home mortgage portfolio of \$100 million, the starting points for the appropriate level of GVAs would be 5 basis points, or \$50,000. Similar to the process outlined above for criticized assets, examiners would then undertake a qualitative analysis of the association to determine appropriate adjustments—up or down—to this amount.

II. Implementation

The OTS proposes to implement the proposed policy on GVAs by issuing guidance to associations and OTS regional staff.

The OTS recognizes that the proposed policy may cause many savings associations to increase the levels of GVAs they currently maintain and, thus, reduce their tangible capital. This will primarily affect associations with high levels of classified assets and those with high historical charge-off levels.

III. Request for Comment

The OTS invites comments from all interested parties on all aspects of the proposed GVA guidance and suggestions for alternative GVA guidance. All comments will be considered when formulating the final policy statement. Commenters are specifically requested to address the following issues:

1. Is the proposed GVA policy guidance appropriate? Will it improve the likelihood that savings associations are establishing appropriate levels of GVAs? Is the proposed policy likely to result in savings associations maintaining GVAs that more accurately reflect the value of their assets and thus enable the OTS to better ascertain the true economic condition of the industry?
2. Are the proposed ranges for Special Mention, Substandard and Doubtful assets appropriate? Are they too wide or too narrow? Is there too much discretion left to associations or examiners?
3. What additional quantitative and qualitative factors should be used to determine appropriate GVA levels for criticized, Pass and unreviewed assets?
4. Is the proposed use of an association's specific net charge-off experience an appropriate starting point for the determination of the adequacy of GVAs for Pass and unreviewed assets? Should the OTS instead use industry-wide loss experience (such as national or regional net charge-off data) as the starting point?
5. Should associations be allowed a transition period to increase their allowances? If so, how should the transition period be structured?
6. Should the OTS have a policy that requires associations and examiners to factor in a "supplemental" amount of GVAs beyond the amount established under the proposal outlined above in order to address the potential for errors in calculations?
7. Is it appropriate for the OTS to adopt the proposed policy guidance before the adoption of similar guidance by the Federal bank regulatory agencies?

Dated: June 29, 1992.

By the Office of Thrift Supervision.

Timothy Ryan,

Director.

[FR Doc. 92-20948 Filed 8-31-92; 8:45 am]

BILLING CODE 6720-01-M

UNITED STATES INFORMATION AGENCY

University Affiliations Program; Application Notice for Fiscal Year 1993

AGENCY: United States Information Agency.

ACTION: Notice; Request for proposals.

SUMMARY: The Bureau of Educational and Cultural Affairs of the United States Information Agency announces a program of support for institutional partnerships between U.S. and foreign universities and colleges with a demonstrated commitment to internationalization of their academic programs. The University Affiliations Program seeks to promote institutional relationships through grants for the exchange of faculty and staff for a period of three years. Participating institutions should be prepared to exchange faculty and staff for teaching, lecturing, and research assignments of one month or longer (preferably three months or one semester); maintain their faculty on full salary and benefits; and receive visiting faculty from the partner institution. USIA grant funds, not to exceed \$100,000, can be used to defray expenses for travel and per diem. A modest amount of the grant total can be allocated for educational materials and communications expenses. Proposals will be accepted either to establish new affiliations or to allow for innovation and strengthening of existing partnerships not previously funded by the University Affiliations Program. Proposals for technical or development assistance projects and feasibility studies to plan affiliations will be not be considered. Research proposals must include collaboration by researchers from both institutions and be linked to substantial participation in graduate-level seminars.

The competition, as described in separate geographic area programs, is limited to selected countries and academic disciplines which represent USIA's geographic and academic priorities for the University Affiliations Program. Subject to the availability of funds, approximately 20-25 grants will be awarded for Fiscal Year 1993.

U.S. institutions are responsible for the submission of proposals and should collaborate with their foreign partners in

planning and preparing proposals. Foreign institutions are encouraged to consult with the U.S. Information Service (USIS) office and/or Fulbright Commission in their countries about the proposed project.

DATES: Deadline for proposals: Proposals must be received at the U.S. Information Agency by 5 p.m. Washington, DC time on January 15, 1993. Proposals received by the Agency after this deadline will not be eligible for consideration. Faxed documents will not be accepted, nor will documents be accepted which are postmarked on January 15, 1993 but received at a later date. It is the responsibility of each grant applicant to ensure that their proposal is received by the above deadline. Grants should begin not later than September 1, 1993.

ADDRESSES: The original and 19 complete copies of the proposal should be submitted by the deadline to: U.S. Information Agency, Ref.: University Affiliations Program, Office of Grants Management, E/XE, room 357, 301 4th St., SW., Washington, DC 20547.

FOR FURTHER INFORMATION CONTACT: For general information and requests for application packets, which include all necessary forms and guidelines for preparing budgets, interested institutions should contact Ms. Camille Barone or Ms. Deborah Trent at (202) 619-5289, or write to the following address: University Affiliations Program, Office of Academic Programs, U.S. Information Agency, 301 4th Street, SW., rm. 349, Washington, DC.

SUPPLEMENTARY INFORMATION:

Overview

Authority for the University Affiliations Program is contained in the Mutual Educational and Cultural Exchange Act of 1961, Public Law 87-256 (Fulbright-Hays Act). The Fulbright Program seeks to increase mutual understanding between the people of the United States and people of other countries. USIA strives to accomplish this goal by promoting affiliations between U.S. and foreign institutions of higher education.

Pursuant to the Bureau's authorizing legislation, programs must maintain a non-political character and should be balanced and representative of the diversity of American political, social and cultural life.

Guidelines

Eligibility

In the U.S., participation in the program is limited to accredited four-year colleges and universities, including

graduate schools and consortia of universities. Overseas, participation is limited to recognized degree-granting institutions of higher education and internationally recognized and highly regarded independent research institutes. Proposals from a consortium may be submitted by a member institution with authority to represent the consortium. Community colleges are eligible only as members of an eligible consortium and not the lead institution, which submits the proposal. Participants traveling under USIA grant support must be U.S. citizens (representing the U.S. institution); and (representing the foreign institution) citizens, nationals, or permanent residents of the country of the foreign partner, who are qualified to hold a valid passport.

The Agency invites proposals from eligible Historically Black Colleges and Universities (HBCUs) and other institutions in the U.S. with significant minority student enrollment. Consortia of universities including such institutions are also strongly encouraged to apply.

Proposed Budget

A comprehensive line item budget should be submitted with the proposal by the deadline. Budget should not exceed \$100,000. Specific guidelines for budget preparation are available in the application packet. Note: Grants awarded to eligible institutions with fewer than four years' experience in conducting international exchange programs will be limited to \$60,000. Budget submissions from these institutions should not exceed this amount.

Geographic Area Programs

The program invites proposals for two-way projects only (involving the U.S. and one foreign country) except for the three-way (Canada-U.S.-Mexico) exchanges. Proposals can focus on one or more eligible academic disciplines.

Africa

Eligible countries are limited to: Botswana, Ethiopia, Nigeria, Senegal, South Africa, Tanzania and Zimbabwe. Eligible academic disciplines are limited to the social sciences, humanities, and the arts. Possible fields include but are not limited to anthropology, archaeology, *American studies, African studies/African-American studies, Islamic studies, economics, law, language and linguistics, literature, political science, public policy, sociology and demography. In addition, the program encourages proposals in comparative religious studies, architecture and urban planning, historic

conservation, museum management and conservation, and parks management. For South Africa, proposals which focus on conflict resolution are also encouraged.

American Republics

Eligible countries are limited to: Bolivia, Chile, Colombia, Ecuador and Peru. Eligible academic fields are: *American studies, economics, environmental studies/natural resource management, political science, and post-secondary education.

East Asia/Pacific

Eligible countries are limited to: Indonesia, Malaysia, and Mongolia. Eligible academic disciplines are limited to the social sciences and humanities. Preference will be given to proposals in *American studies, Islamic studies, comparative religious studies, education, environmental studies, international business/management, international law, and political science.

Europe

Eligible countries are limited to: Albania, Bulgaria, Czech and Slovak Federal Republic (limited to universities outside Prague and Bratislava), Romania, Turkey, and the following Newly Independent States: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. Russia is excluded in this year's competition due to the large number of existing linkages with that country. Eligible academic fields are limited to the social sciences, humanities, and the arts. Preference will be given to proposals in *American studies, Islamic studies, comparative religious studies, business administration, communications (including journalism), economics, educational administration and reform, environmental studies, fine/performing arts, history, historic conservation, law, psychology (non-clinical), public administration, public policy analysis, political science, and sociology.

North Africa/Near East/South Asia

Eligible countries/regions are limited to: Algeria, Bahrain, Bangladesh, Egypt, Israel, Jordan, Kuwait, Mauritania, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, West Bank, Gaza, and Yemen. Eligible academic disciplines are limited to the social sciences and humanities. Preference will be given to

proposals in *American studies, Islamic studies, comparative religious studies, economics, environmental policy studies, journalism, and public administration.

Trilateral Exchanges: Canada-U.S.-Mexico

The Agency also invites proposals for three-way projects linking an institution in the U.S. with institutions in Canada and Mexico. Eligible academic disciplines are: The humanities and the arts, comparative education and culture, environmental studies, economics, and international business and trade.

This program encourages the expansion of trilateral educational exchange between Canada and the U.S. and Mexico. The objective is to broaden opportunities for educational and cultural exchanges among these countries, thereby enriching their respective educational systems.

Application Requirements

Proposals must be submitted within the deadline and conform to the selected countries and academic fields identified under the geographic area programs. The proposal package should include one original and 19 complete copies and all required documentation. Proposals should be presented as follows:

1. *A proposal cover sheet* (in addition to the Bureau cover sheet) with names of both institutions, name of foreign country, project directors including their addresses, telephone and fax numbers, and academic field(s) of proposal. A sample cover sheet format is included in the application packet.

2. *An executive summary* (abstract) of proposed project, not to exceed one single-spaced page.

3. *A narrative*, not to exceed twenty double-spaced pages, including descriptions of institutions and participating academic departments or schools; a detailed description of the proposed affiliation program, including names and qualifications of designated project directors; a statement of need for the proposed program; a detailed description of proposed activities, including who will travel, when, where, and how activities will occur for each of the three years; anticipated benefits of the program to participating institutions; a plan for institutional evaluation of the project; and evidence of the institutions' commitment to the internationalization of their academic programs, e.g. through

Note: American studies includes the fields of American history, civilization, literature, social sciences, and the arts.

international partnerships, student exchanges, etc.

4. *A comprehensive line item budget* outlining specific expenditures and sources from which funds are anticipated. Detailed information concerning eligible and ineligible items and required budget format is available in the application packet.

5. *Documentation of institutional support* for the proposed linkage, including signed letters of endorsement from the U.S. and foreign institutions' presidents, chancellors, or directors making specific reference to the 1993 University Affiliations Program and committing their participating institution(s) to maintaining their exchange participants on full salary and benefits during the exchange. *A general letter of support or an agreement between the two institutions without reference to the maintenance of salaries and benefits will not fulfill this requirement.* A sample letter of endorsement and commitment is included in the application packet.

6. *Brief academic resumes*, not to exceed two single-spaced pages, of participating faculty/staff from both institutions, clearly indicating level of language skills, overseas experience, knowledge of prospective partner country, relevant scholarly and non-scholarly travel, publications, and research activities.

Note: All pages in excess of the two-page limit will be discarded.

Review Process

The University Affiliations Program review process is conducted in three stages: Technical, academic, and Agency. Proposals will be deemed ineligible if they do not adhere to the guidelines established herein and in the application packet. Eligible proposals will be forwarded to outside academic panels for advisory review. All proposals recommended for funding will be reviewed in the Agency by the Office of Academic Programs, the appropriate geographic area office, and the budget and contracts offices. Funding decisions are at the discretion of the Associate Director for Educational and Cultural Affairs. Grant awards will be submitted for approval to the J. William Fulbright Foreign Scholarship Board. Final technical authority for grant awards resides with USIA's contracting officer.

Upon completion of the technical review, applicants will be notified in

writing of the status of their proposals. A grace period will be granted to applicants whose proposals lack the following:

A signed letter of endorsement from the president, chancellor, or director of the foreign institution, making specific reference to the 1993 University Affiliations Program and committing the institution to maintaining their exchange participants on full salary and benefits during the exchange. The deadline for submission of this document is 5 p.m. Washington, DC time on January 29, 1993.

Review Criteria

Academic Review Criteria

Proposals are reviewed by independent academic peer panels with geographic and discipline expertise which make recommendations to the Agency based on the following criteria:

1. Soundness of proposal indicating academic quality, as reflected by a clear statement of program goals and means to accomplish the goals, and detailed description of project with statement on how the proposed project will be implemented and evaluated.
2. If the proposal requests support for an established active linkage, evidence that the University Affiliations funding would result in innovation in the exchange relationship.
3. Promise of the production of new skills/knowledge and advancement of scholarship in fields covered by the program.
4. Evidence that theme(s) of proposed project fits field(s) stated in the announcement.
5. Evidence of strong mutual benefits to the institutions involved in the exchanges.
6. Feasibility of the program plan as it relates to the stated goals and selected topics and activities.
7. Academic quality of credentials/experience of participants in relation to the goals of the proposed exchange plan (including linguistic proficiency, where required).
8. Appropriateness of length of exchange visits given project goals.
9. Evidence of strong institutional commitment by participating institutions.
10. Evidence of a strong commitment to internationalization of their academic programs by participating institutions.
11. Evidence of mutual advancement of cultural and political understanding

of the countries or geographic areas represented in the partnership through development of individual and institutional ties.

12. For proposals focused on research as its primary activity: Inclusion of collaboration by researchers from both institutions, linked to substantial participation in graduate-level seminars.

13. Evidence that the partnership is likely to continue after the expiration of the USIA grant.

Agency Review Criteria

USIA will consider for further review only those proposals recommended by academic review panels. Agency considerations will be based on:

1. Academic quality, reflected in academic review panel's comments and recommendations
2. Feasibility of program plan
3. Advancement of mutual cultural and political understanding between the countries or geographic areas represented in the partnership
4. USIA overseas post assessments of need and feasibility
5. Promise of long-term impact
6. Cost-effectiveness
7. Submission by institutions with significant minority enrollment, applying alone or in consortia with other U.S. institutions.

Notice

The terms and conditions published in this RFP are binding and may not be modified by any USIA representative. Explanatory information provided by the Agency that contradicts published language will not be binding. Issuance of the RFP does not constitute an award commitment on the part of the Government. Final award cannot be made until funds have been fully appropriated by Congress, allocated and committed through internal USIA procedures.

Notification

All applicants will be notified of the results of the review process on or about July 1, 1993. Awarded grants will be subject to periodic reporting and evaluation requirements.

Dated: August 26, 1992.

Barry Fulton,

Acting Associate Director, Bureau of Educational and Cultural Affairs.

[FR Doc. 92-21031 Filed 8-31-92; 8:45 am]

BILLING CODE 8230-01-M

Sunshine Act Meetings

Federal Register

Vol. 57, No. 170

Tuesday, September 1, 1992

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

AGENCY: AGENCY HOLDING THE MEETING:

Nuclear Regulatory Commission.

DATE:

Weeks of August 31, September 7, 14, and 21, 1992.

PLACE:

Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS:

Open and Closed.

MATTERS TO BE CONSIDERED:

Week of August 31

Tuesday, September 1

3:00 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Thursday, September 3

1:00 p.m. Briefing by EPRI on Status of EPRI Design Requirements Document for Advanced Light Water Reactors (PUBLIC MEETING)

Week of September 7—Tentative

Tuesday, September 8

10:00 a.m. Briefing on Advanced and Evolutionary Reactor Topics: Form and Content for a Design Certification Rule and Follow-up to SECY-90-016 (PUBLIC MEETING) (Contact: Dennis Crutchfield, 301/504-1199)

Wednesday, September 9

3:30 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Friday, September 11

8:00 a.m. Discussion of Management-Organization and Internal Personnel Matters (CLOSED—Ex. 2 and 6)

8:30 a.m. Briefing by Charles Meinhold on 1990 Recommendations of the International Commission on Radiological Protection (ICRP Publication 60) (PUBLIC MEETING)

10:00 a.m. Periodic Meeting with the Advisory Committee on Reactor Safeguards (ACRS) (PUBLIC MEETING) (Contact: Raymond Fraley, 301/492-8049)

Week of September 14—Tentative

Monday, September 14

2:00 p.m. Briefing on Electricity Forecast from Energy Information Administration (EIA) Annual Energy Outlook (PUBLIC MEETING)

Thursday, September 17

2:00 p.m. Status Briefing on Shutdown and Low Power Risk Issues (PUBLIC MEETING) (Contact: Mark Caruso 301/504-3235)

3:30 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Week of September 21—Tentative

Thursday, September 24

11:30 a.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

note: Affirmation sessions are initially scheduled and announced to the public on a time-reserved basis. Supplementary notice is provided in accordance with the Sunshine Act as specific items are identified and added to the meeting agenda. If there is no specific subject listed for affirmation, this means that no item has as yet been identified as requiring any Commission vote on this date.

To verify the status of meeting call (recording)—(301) 504-1292.

CONTACT PERSON FOR MORE INFORMATION:

William Hill (301) 504-1661.

Dated: August 27, 1992.

William M. Hill, Jr.,

Office of the Secretary.

[FR Doc. 92-21123 Filed 8-28-92; 3:23 pm]

BILLING CODE 7590-01-M

Corrections

Federal Register

Vol. 57, No. 170

Tuesday, September 1, 1992

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

FEDERAL ELECTION COMMISSION

11 CFR Part 200

[Notice 1992-12]

Administrative Regulations

Correction

In rule document 92-18473 beginning on page 34508 in the issue of Wednesday, August 5, 1992, make the following correction:

§ 200.1 [Corrected]

On page 34510, in the first column, in § 200.1, in the first line, "prescribed" should read "prescribes".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 410

[BPD-423-F]

RIN 0938-AD25

Medicare Program; Fee Schedules for the Services of Certified Registered Nurse Anesthetists

Correction

In rule document 92-16943 beginning on page 33878 in the issue of Friday, July 31, 1992, make the following correction on page 33896, in the second column, under Part 410, in the Authority citation, in the third line, remove "7."

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1002

[Ex Parte No. 246 (Sub-No. 10)]

Regulations Governing Fees for Services Performed in Connection With Licensing and Related Services—1992 Update

Correction

In proposed rule document 92-18949 beginning on page 35557 in the issue of Monday, August 10, 1992, make the following corrections:

§ 1002.2 [Corrected]

1. On page 35558, in the first column, in § 1002.2(f), in entry (1), in the third line, "certification" should read "certificate".

2. On the same page, in the second column, in the same section, in entry (14), "Reserved" should read "[Reserved]".

3. On the same page, in the third column, in the same section, in entry (40), insert a period after "railroads".

4. On page 35559, in the first column, in the same section, in entry (50), in the second line, insert a period after "competition".

5. On the same page, in the same column, in the same section, in entry (54)(i), in the sixth line, insert "; or an application" after "authorization".

6. On the same page, in the second column, in the same section, in footnote 2, "band." should read "bond."

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1109

[Ex Parte No. 55 (Sub No. 83)]

Use of Alternative Dispute Resolution Procedures in Commission Proceedings and Those In Which the Commission is a Party

Correction

In the correction to rule document 92-17290 appearing on page 35628 in the issue of Monday, August 10, 1992, the docket number should read as set forth above.

BILLING CODE 1505-01-D

DEPARTMENT OF JUSTICE

Antitrust Division

Pursuant to the National Cooperative Research Act of 1984; Southwest Research Institute

Correction

In notice document 92-16019 beginning on page 30510 in the issue of Thursday, July 9, 1992, make the following corrections:

On page 30511, in the first column, in the first complete paragraph, in the sixth line, "Mobile" should read "Mobil" and in the same paragraph, in the ninth line, "Texas" should read "Texaco".

BILLING CODE 1505-01-D

RESOLUTION TRUST CORPORATION

12 CFR Part 1625

Procedures Applicable to RTC Investigations

Correction

In proposed rule document 92-16545 beginning on page 33133 in the issue of Monday, July 27, 1992, on page 33134, in the first column, in the fourth full paragraph, in the seventh line, after "provisions" insert "specified therein. The confidentiality provisions".

BILLING CODE 1505-01-D

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[EE-23-92]

RIN 1545-AQ66

Voluntary Employees' Beneficiary Association Qualification—Geographic Locale Restriction

Correction

In proposed rule document 92-18532 beginning on page 34886 in the issue of Friday, August 7, 1992, make the following corrections:

1. On page 34886, in the second column, under **BACKGROUND**, in the first paragraph, in the 3d line from the end of the paragraph, after "same" insert "line of business in the same".

2. On page 34887, in the 1st column, in the last paragraph, in the 11th line, "or" should read "of".

3. On the same page, in the second column, in the last paragraph, in the 8th line, "section 502" should read "section 501".

BILLING CODE 1505-01-D

**Estimate
for
Federal**

Tuesday
September 1, 1992

Part II

**Department of
Health and Human
Services**

Health Care Financing Administration

42 CFR Parts 412 and 413

**Medicare Program; Changes to Hospital
Inpatient Prospective Payment Systems
and Fiscal Year 1993 Rates; Final Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-756-F]

RIN 0938-AF79

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the systems. In addition, in the addendum to this final rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes will be applicable to discharges occurring on or after October 1, 1992. We are also setting forth rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems.

Finally, we are changing and clarifying the criteria and procedures concerning the reclassification of hospitals by the Medicare Geographic Classification Review Board (MGCRB). These changes result from public comment and our analysis of hospital reclassifications for Federal fiscal year (FY) 1992.

EFFECTIVE DATE: The provisions of this final rule are effective on October 1, 1992. The changes in Section IV concerning the reclassification of hospitals by the MGCRB will apply for applications received by October 1, 1992 for geographic reclassifications to be implemented on October 1, 1993 (FY 1994).

FOR FURTHER INFORMATION CONTACT: Barbara Wynn (410) 966-4529.

ADDRESSES: To order copies of the Federal Register containing this document, send your request to: Government Printing Office, ATTN: New Order, P.O. Box 371954, Pittsburgh, PA 15250-7954.

Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-2465 or by faxing your request to (202) 512-2250. The cost for each copy

(in paper or microfiche form) is \$1.50. When requesting copies of the Federal Register document please refer to stock number 069-001-00044-1. To purchase copies of Tables 3C, 5, 7A and B, and 9 in electronic form, contact the U.S. Government Printing Office by telephone at (202) 512-1530 or by fax at (202) 512-1262. In addition, you may view and photocopy the Federal Register document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries throughout the country that receive the Federal Register. Ask the order desk operator for the locations of the U.S. Government Depository Libraries.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), a system of payment for the operating costs of acute hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment for hospital inpatient operating costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. On August 30, 1991, we published a final rule (56 FR 43196) to implement changes to the prospective payment system for hospital operating costs for Federal fiscal year (FY) 1992.

For cost reporting periods beginning before October 1, 1991, hospital inpatient operating costs were the only costs covered under the prospective payment system. Payment for capital-related costs had been made on a reasonable cost basis because, under sections 1886(a)(4) and (d)(1)(A) of the Act, those costs had been specifically excluded from the definition of inpatient operating costs. However, section 4006(b) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) revised section 1886(g)(1) of the Act to require that, for hospitals paid under the prospective payment system for operating costs, capital-related costs would also be paid under a prospective payment system effective with cost reporting periods beginning on or after October 1, 1991.

Therefore, on August 30, 1991, we published an additional final rule (56 FR 43358) in which we revised the Medicare payment methodology for inpatient

capital-related costs for hospitals paid under the prospective payment system for operating costs. As required by section 1886(g) of the Act, we replaced the reasonable cost-based payment methodology with a prospective payment methodology for hospital inpatient capital-related costs. Under the new methodology, effective for cost reporting periods beginning on or after October 1, 1991, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs.

We established the standard Federal rate for FY 1992 using the FY 1989 Medicare inpatient capital cost per discharge updated to FY 1992 by the estimated increase in Medicare capital costs per discharge. In addition, we established a 10-year transition period for hospitals to be paid for their capital-related costs under one of two different payment methods. Generally, a hospital with a FY 1992 hospital-specific rate below the Federal rate is paid based on a fully prospective payment methodology. A hospital with a FY 1992 hospital-specific rate at or above the Federal rate is paid based on a hold-harmless method or 100 percent of the Federal rate, whichever results in a higher payment. Beginning with hospital cost reporting periods beginning on or after October 1, 2001, all hospitals are paid the Federal rate except for certain new hospitals that have not completed their transition period. (See the August 30, 1991 final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

Hospitals and hospital distinct-part units that are excluded from the prospective payment system under the regulations at part 412, subpart B continue to be paid for capital-related costs on a reasonable cost basis under the provisions of part 413, subpart C. Also, rural primary care hospitals are not currently subject to prospective payment rules as provided under section 1814(l) of the Act and the last sentence of section 1861(e) of the Act.

B. Summary of the Provisions of the June 4, 1992 Proposed Rule

On June 4, 1992, we published a proposed rule in the Federal Register (57 FR 23618) to amend the prospective payment systems for operating costs and capital-related costs as follows:

- We proposed changes for FY 1993 DRG classifications and weighting factors as required by section 1886(d)(4)(C) of the Act. This section requires that we adjust the DRG classifications and relative weights at least annually.

• We proposed a revised wage index for discharges occurring on or after October 1, 1992 that incorporated all reclassifications of hospitals based on decisions made by the Medicare Geographic Classification Review Board (MCCRB) as of March 30, 1992. The proposed wage index also incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented for FY 1992 in the August 30, 1991 final rule (56 FR 43196).

• We discussed the criteria and procedures for hospital reclassifications by the Medicare Geographic Classification Review Board and set forth proposed changes concerning the following:

- General guidelines—reclassifications for individual hospitals.
 - + Reclassification to a single geographic area.
 - + Individual urban hospital reclassification to a rural area.
 - + Special access rule for rural referral centers and sole community hospitals seeking reclassification.
 - + Guidelines for a hospital requesting reclassification for wage index purposes.
 - + Application of numeric standards.
- Implementation of FY 1994 hospital reclassifications.
 - + Appropriate wage data.
 - + Revised labor market areas.
- Administrative and procedural guidelines.
 - + Withdrawing an application.
 - + Reopenings.

• We discussed the prospective payment system for inpatient operating costs in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning:

- Outlier payments.
- Rural referral center criteria.
- Direct graduate medical education payments.

• We discussed several provisions of the regulations at 42 CFR part 412, subpart M, concerning capital prospective payment system rules, and proposed changes concerning the following:

- Payments to new hospitals.
- Portions of hospital assets put in patient care service after December 31, 1990.
- Treatment of old capital costs when hospitals are leased after December 31, 1990.
- Obligated capital costs.
- Adjusting the hospital-specific rate—transfer adjusted discharge and case-mix index for subsequent base periods.
- Redetermination of the hospital-specific rate.

- Effect of hospital mergers, consolidations or dissolution on the hospital-specific rate.
- Extraordinary circumstances exceptions payments.
- Minor technical corrections.

• We discussed changes to the regulations at 42 CFR parts 412 and 413 for hospitals and units excluded under the prospective payment system. The proposed changes concerned the following:

- Provisionally excluded hospitals and units.
- Definition of discharge for purposes of applying the rate-of-increase limits applicable to excluded hospitals and distinct part units.
- New hospital exemption applicable to excluded hospitals.
- Adjustments under the rate-of-increase ceiling.

• In the addendum to the proposed rule, we set forth changes to the amounts and factors for determining the FY 1993 prospective payment rates for operating costs and capital-related costs. We also proposed new target rate percentages for determining the rate-of-increase limits for cost reporting periods beginning in FY 1993 for hospitals and hospital units excluded from the prospective payment system.

• In Appendix A of the proposed rule, we set forth an analysis of the impact that the changes described in the proposed rule would have on affected entities.

• In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 1993 capital acquisition model and budget neutrality adjustment.

• In appendix C of the proposed rule, we set forth our initial estimate of an update factor for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system, as required by section 1886(e)(3)(B) of the Act.

• In Appendix D of the proposed rule, we provided our recommendation of the appropriate percentage changes for FY 1993, as required by sections 1886(e)(4) and (e)(5) of the Act, for the following:

- Large urban, other urban, and rural average standardized amounts (and hospital-specific rates applicable to sole community hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

In the June 4, 1992 proposed rule, we also discussed in detail the March 1, 1992 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986 and thereafter. In addition, section 1886(e)(2)(B) of the Act directs ProPAC to make recommendations regarding changes in each of the Medicare payment policies under which payments to an institution are prospectively determined. In particular, the recommendations relating to the hospital inpatient prospective payment systems are to include recommendations concerning the number of DRGs used to classify patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. As set forth in section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2)(A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We printed ProPAC's March 1, 1992 report, which includes its recommendations, as appendix E of the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action is recommended), were discussed in detail in the appropriate sections of the preamble, the addendum, or the appendixes of the proposed rule.

Set forth below in sections II, III, IV, V, VI, and VII of this preamble, the addendum to this final rule, and the appendixes, are detailed discussions of the June 4, 1992 proposed rule, the public comments received in response to that proposal, and the responses to those comments as well as any changes we are making. Appendix C sets forth a modified framework for developing the update for the prospective payment system for inpatient hospital operating costs that we are considering for FY 1994. Also, we are adding a new appendix D, which sets forth a preliminary framework for developing the update for the prospective payment system for inpatient hospital capital-related costs. As discussed in the appendixes, we are inviting suggestions for improvements that could be made in these frameworks before we propose to implement them in future rulemaking documents.

C. Number and Types of Public Comments Received in Response to the June 4, 1992 Proposed Rule

A total of 527 items of correspondence containing comments on the June 4, 1992 proposed rule were received timely. The main areas of concern addressed by commenters were the following:

- The proposed changes in the criteria for the geographic reclassification of hospitals for purposes of the wage index.
- Proposed changes to the payment methodology for day outliers and the amounts of the FY 1992 outlier payments.
- Proposed changes to the capital prospective payment system rules.
- The rate of increase in the market basket and the update to the standardized amounts.
- The proposed revisions to rate-of-increase limits for hospitals and units excluded from the prospective payment system.
- Requests for changes in DRG classification and relative weights.

II. Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for hospital inpatient services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in other DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1992 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment

system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.¹ The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims, cases are classified by the GROUPEER software program into the appropriate DRG. The GROUPEER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment.

Currently, cases are assigned to one of 489 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

In general, principal diagnosis determines MDC assignment. However, there are four DRGs to which cases are assigned on the basis of procedure codes rather than first assigning them to an MDC based on the principal diagnosis. These are the DRGs for liver and bone marrow transplant (DRGs 480 and 481, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical

DRGs are further differentiated based on the presence or absence of complications or comorbidities (hereafter CC).

Generally, GROUPEER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPEER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

We proposed to make several changes to the DRG classification system. These proposed changes and the comments we received concerning them as well as our responses are set forth below.

2. Reassignment of Certain Endoscopic Procedures (DRGs 76 and 77)

Currently, the only endoscopic procedure performed on the respiratory system that is considered an OR procedure is procedure code 33.27 (Closed endoscopic biopsy of lung). This procedure code is assigned to DRG 76 or 77 (Other Respiratory System OR Procedures)² if the patient's principal diagnosis is classified in MDC 4 (Diseases and Disorders of the Respiratory System). If procedure code 33.27 is performed in connection with a principal diagnosis assigned to another MDC, and no other procedure related to that diagnosis is performed, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis).

Based on inquiries from the industry as well as our own concerns, we have reviewed the appropriate assignment of two other respiratory system endoscopic procedures: Endoscopic excision or destruction of lesion or tissue of lung (procedure code 32.28) and Closed [endoscopic] biopsy of bronchus (procedure code 33.24). Currently, performance of these non-OR procedures affects DRG assignment only in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms). For principal diagnoses that are assigned to that MDC, the performance of procedure codes 32.28 or 33.24 results in assignment to medical

¹ Effective with discharges occurring on or after October 1, 1991, we allowed an expansion of the number of reported diagnosis and procedure codes from 5 to 9 and from 3 to 6, respectively. Hospitals are required to code at the new level effective with discharges occurring on or after April 1, 1992.

² A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second is for cases without CC. If a third number is included, it represents cases of patients who are age 0-17. Occasionally, a pair of DRGs are split on age > 17 and age 0-17.

DRG 412 (History of Malignancy with Endoscopy).

As a result of our analysis of the FY 1991 Medicare provider analysis and review file (MEDPAR) data, we proposed that endoscopic procedure codes 32.28 and 33.24 be designated as OR procedures and assigned to DRGs 76 and 77 in MDC 4. In addition, if procedure code 32.28 or 33.24 appears on a claim with a principal diagnosis in MDC 17, it would be assigned to surgical DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other OR Procedure) rather than DRG 412.

Although we received no comments on changing the status of the endoscopic procedure codes from non-OR to OR, we have reevaluated our proposal based on more recent information. In modeling the impact of the proposed DRG classification and recalibration changes, we must estimate which cases would be affected by the changes because we do not have a revised GROUPEER program at the time the proposed rule is prepared. Thus, our analysis in the proposed rule of the impact of the DRG changes was based on an approximation of the placement of the cases under the proposed reclassification and the resulting recalibration of the DRG weights.

When we receive the revised GROUPEER software, we can more accurately test the DRG classification and recalibration changes. This year, after testing the changes, we discovered that the DRG changes including the reassignment of the two endoscopic procedures would have a much more significant negative impact on small hospitals than we had stated in the proposed rule. For example, rural hospitals with under 50 beds would have an average reduction in payment per case of 0.6 percent and rural hospitals with 50 to 99 beds would have an average reduction of 0.3 percent. In the proposed impact analysis, we estimated these reductions at 0.2 and 0.1, respectively (57 FR 23819). The increase in the negative impact is entirely due to the endoscopic change. As the affected hospitals did not have an opportunity to comment on this significant impact on their payments, we believe it would be unfair to proceed with the change at this time. Therefore, we are not making this change effective for FY 1993.

3. Automatic Implantable Cardioverter Defibrillator (AICD) Procedures (DRG 120)

For several years, we have received a great deal of correspondence concerning the appropriate DRG assignment of

certain procedures involving automatic implantable cardioverter defibrillators (AICDs). Currently, when a patient whose principal diagnosis is classified to MDC 5 (Diseases and Disorders of the Circulatory System) receives a total AICD system implant or replacement (procedure code 37.94), the case is assigned to DRG 104 or 105 (Cardiac Valve Procedures with or without Cardiac Catheterization). However, if a procedure is performed that involves the implantation or replacement of only part of the AICD system (that is, replacement or implant of either the leads or pulse generator only), the case is assigned to DRG 120 (Other Circulatory System OR Procedures). The related procedure codes are the following: 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only), 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only), 37.97 (Replacement of cardioverter/defibrillator lead(s) only), and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only). We note that if a case is coded with a pair of codes that indicates total implant (37.95 and 37.96) or total replacement (37.97 and 37.98), it groups to DRG 104 or 105.

After reviewing the current DRGs in terms of clinical coherence and similar resource use, we proposed to reassign procedure codes 37.95, 37.96, 37.97, and 37.98, when they do not occur as pairs, to DRG 116 (Permanent Cardiac Implant without AMI, Heart Failure, or Shock). As explained in the proposed rule, the relative weight for DRG 116 is higher than that of both DRGs 112 (Percutaneous Cardiovascular Procedures) and 120 and, from a clinical perspective, we believe that the surgical implant of an AICD device is similar to a pacemaker implant. (Cases of an AICD lead or generator procedure are assigned to DRG 112 when electrophysiologic (EP) studies are also performed.) In addition, we proposed a new title for DRG 116 "Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure."

Comment: While our proposal to reassign procedure codes 37.95, 37.96, 37.97, and 37.98 to DRG 116 met with general approval, we received many comments urging that these codes be reassigned to DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock) instead. The commenters state that these cases will continue to be underpaid in DRG 116 and that reassignment to DRG 115 is more reasonable in terms of both clinical coherence and resource use. Many commenters believe that the AICD cases are as complicated as the

cases that currently group to DRG 115. That is, in many cases, the AICD device is being placed in high-risk ventricular arrhythmia patients with poor left ventricular cardiac function, which is as risky as implanting a pacemaker in a patient with AMI, heart failure, or shock.

As a result of a study commissioned by the AICD manufacturer, the commenters estimate that these procedures should be assigned to a DRG with a weight of at least 3.7966, based on an average charge of \$26,396 for correctly coded and billed AICD cases. The proposed weights for DRGs 115 and 116 were 3.6230 and 2.4759, respectively. (Several of the commenters mistakenly reported a proposed weight of 3.8230 for DRG 115.) Therefore, the commenters assert that assignment of AICD cases to DRG 115 would be much more equitable. Several commenters also alleged that hospitals are limiting the availability of the AICD device to Medicare patients as a response to the current level of compensation.

Response: As explained in the proposed rule (57 FR 23621), the current clinical composition and weights of the surgical DRGs in MDC 5 do not offer a perfect match with the AICD cases. After reviewing the current DRGs in terms of clinical coherence and similar resource use, we determined that DRG 116 was the best fit possible.

Since publication of the proposed rule, we have reanalyzed these cases based on the most recent update to the FY 1991 MEDPAR file. Based on those data, the average standardized charge for AICD cases is now \$19,550 for the 971 cases assigned to DRG 120 and \$32,363 for the 288 cases assigned to DRG 112. Thus, the overall average standardized charge for the 1,259 cases is \$22,481. If the cases currently assigned to DRGs 117, 118, 478, and 479 are included in the calculation, the average standardized charge is \$22,427 (1,284 cases). The average standardized charge for all cases assigned to DRG 116 is \$17,224 and \$25,737 for DRG 115.

The difference in average charges between our analysis and the analysis performed for the commenters is that we have included all the cases in our data base and they have excluded those cases they believe to be incorrectly coded or for which the charges reported by the hospital appear to be too low. In the proposed rule, we described the measures we had taken in an attempt to improve the charge and coding information on AICD cases. In May 1991, we instructed fiscal intermediaries to return to hospitals any bill for an AICD case for which the total charges

were less than \$17,000 (the minimum charge necessary based on the cost of the device (\$13,500) and a 4-day inpatient stay). (See Transmittal No. 1525.) This action was designed to ensure proper coding and charge information for these cases.

We have performed a separate analysis using data from bills submitted after June 1, 1991, the date we believe all intermediaries should have had the charge edit in place. Using these data, the average standardized charges for AICD cases in DRGs 112 and 120 are \$32,714 and \$20,789, respectively. These charges are slightly higher than the charges for all cases; therefore, we believe that the steps we have taken are improving the AICD data in the MEDPAR. Nonetheless, we continue to believe that we should use all the cases in the MEDPAR file in calculating the average standardized charges and in assessing the correct DRG placement for a set of cases.

In reviewing the average charges and the best placement for AICD cases, we note that it is only those cases assigned to DRG 120 that are likely to be AICD-only cases. That is, cases currently assigned to DRGs 112, 117, 118, 478, and 479 that include the performance of an AICD implant also include the performance of another heart-related procedure. Therefore, the charges for these cases encompass resource use for at least one other procedure. For example, an AICD case in DRG 112 has also had either a percutaneous transluminal coronary angioplasty (PTCA) or electrophysiologic (EP) studies performed. Therefore, it is more than likely that the average charge for these cases will be higher than the charges for the single procedure cases within the DRG. In fact, when reviewing the DRG 120 cases, the average charge for an AICD case is only \$19,550. This charge is only about \$2,300 more than the average charge for other cases in DRG 116 and is well within the variation in charges for that DRG. We believe that it is important to note these facts even though the remainder of our discussion of the data includes all AICD cases.

With regard to the commenters' statement that the cases receiving AICD devices are as complicated as the cases in DRG 115, we rely on two factors to assess that assertion. First, the average charge for the universe of AICD cases is approximately \$3,300 less than the average charge for a case assigned to DRG 115. In addition, the average length of stay for the DRG 115 cases is 13.6 days compared to 7.7 days for the AICD cases in DRG 112 and 4.0 days for the DRG 120 cases. Using the same universe

of 1,284 cases as we did in the average charge analysis, we compute an average length of stay of 6.7 days. Not only is this length of stay far lower than the one for DRG 115, it is actually lower than the average for DRG 116 (7.1 days). Thus, it is clear that, regardless of the condition of these patients, they are not remaining in the hospital for the same length of time as the DRG 115 and 116 patients. This leads us to conclude that they are neither as severely ill nor as complex to treat as the DRG 115 cases.

We believe that the cost of the AICD device is largely responsible for the high average charge for these cases. If the cost of the device (\$13,500) is subtracted from the average charge for the case, the charge for the hospital resources consumed is only \$6,050 for DRG 120 cases, \$18,863 for DRG 112 cases, and \$8,927 for all cases. Thus, the largest component of the charge is for the device, which is currently marketed by a single manufacturer. Based on conversations we have recently had with other device manufacturers as well as staff at the Food and Drug Administration (FDA), we understand that up to three other implantable defibrillator devices may be approved by the FDA in the near future. With increased competition, there may be a decrease in the price of these devices and a corresponding drop in the average charge for a hospital stay for AICD implantation. Pending these developments and future improvements in code and charge reporting, we believe our best course is to assign the AICD cases to DRG 116 as proposed and review our decision in the future as circumstances change.

Finally, with regard to the commenters' concern that hospitals are limiting the availability of the AICD device to Medicare beneficiaries, we note that the regulations at 42 CFR 489.53(a)(2) provide that HCFA may terminate a hospital's Medicare provider agreement if it finds that the hospital places restrictions on the number of Medicare beneficiaries it will accept for a particular treatment if it does not place the same restriction on the other populations it treats. Therefore, individuals and groups that are aware of specific cases where a hospital has refused to provide this covered service to a beneficiary should provide this information to us for review.

4. Major Joint and Limb Reattachment Procedures of Lower Extremity (DRG 209)

As a part of the DRG changes set forth in the August 30, 1991 final rule, we revised the classification of cases assigned to DRG 209. Before October 1,

1991, DRG 209 was titled: "Major Joint and Limb Reattachment Procedures", and procedures of both the upper and lower extremity were assigned that DRG. Effective with discharges occurring on or after October 1, 1991, former DRG 209 was split into two DRGs: DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and DRG 491 (Major Joint and Limb Reattachment Procedures of Upper Extremity). (See 56 FR 43205.)

In the August 30, 1991 final rule, in response to a comment we received on the DRG 209 change, we stated that we would analyze the appropriate assignment of major limb reattachment procedures as part of our analysis of potential FY 1993 changes. We analyzed the FY 1991 MEDPAR data for limb reattachment cases and found that there were no major limb reattachment cases in the 10 percent sample of all Medicare cases that we use for analyzing possible classification changes. That is, in the 10 percent sample, there were no cases of limb reattachments (of either upper or lower extremities) found in any DRG, including DRG 209 and DRG 485 (Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma). While these limb reattachment cases may be different clinically and in terms of resource consumption from the major joint replacement cases in DRG 209 and from the other cases in DRG 485, these cases appear to be especially rare in the Medicare population. Based on the lack of supporting data and the fact that few reattachment procedures are performed, we did not propose any changes to the DRG assignment of major limb reattachment cases.

Comment: One commenter expressed concern that the evaluation of the appropriateness of DRG classification changes, in particular the decision not to make a change in the DRGs for limb reattachment cases, is based on only a sample of MEDPAR cases, rather than the entire MEDPAR file. The commenter stated that it appears to be appropriate to search all records before concluding that no change should be made.

Response: The data we analyzed in deciding whether or not to reassign the major limb reattachment procedures was a 10 percent random sample of the September 1991 update of the FY 1991 MEDPAR, which contained approximately 9.5 million cases. We have found that a 10 percent sample (approximately 1 million claims) is fully representative of the 100 percent file and is completely reliable as a basis for making decisions about DRG revisions.

In response to this comment, using the June 1992 update of the FY 1991

MEDPAR file, which contains approximately 10.4 million Medicare discharges, we searched the entire file for major limb reattachment cases. The limb reattachment procedure codes 84.23 (Forearm, wrist, or hand reattachment), 84.24 (Upper arm reattachment), 84.26 (Foot reattachment), 84.27 (Lower leg or ankle reattachment), and 84.28 (Thigh reattachment). In FY 1991, these procedures were assigned to DRGs 209, 441 (Hand Procedures), 442 and 443 (Other OR Procedures for Injuries), 459 (Nonextensive Burns with Wound Debridement or Other OR procedure), 472 (Extensive Burns with OR Procedure), 485, and 486 (Other OR Procedures for Multiple Significant Trauma). In these DRGs, we found only four cases: Two in DRG 209 and one each in DRGs 441 and 443. All of these cases were reattachments of the upper extremity.

(Note: The upper extremity case in DRG 209 in FY 1991 would be classified in DRG 491 effective October 1, 1991.)

An additional 15 cases of major limb reattachment were found in the review of the full FY 1991 MEDPAR. Of these cases, 11 cases were assigned to DRG 424 (O.R. Procedure with Principal Diagnosis of Mental Illness), which consisted of 9 cases of lower leg or ankle reattachments and 2 cases of forearm, wrist, or hand reattachments. The following DRGs each had one case: DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe), DRG 357 (Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy), DRG 440 (Wound Debridements for Injuries), and DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). All these cases were forearm, wrist, or hand reattachments, except for the DRG 468 case, which is an upper arm reattachment.

The total standardized charges for the 19 cases range from \$1,113 to \$74,718, with an average charge of \$23,731. The lengths of stay range from 1 to 123 days, with an average length of stay of 36 days. These cases were distributed across 19 hospitals, that is, each hospital had only one case.

Based on this analysis, we believe that our proposed decision to make no changes for major limb reattachments was correct. There were only two cases in DRG 209, the DRG from which the commenter wished to move these cases. The charges for these cases were well within the expected variation of charges for cases in this DRG. With a universe of only 19 cases, of which only 4 occurred in DRGs to which the procedures are

assigned, and the wide distribution of these cases among hospitals, we continue to believe that there is no support for the creation of a separate DRG for limb reattachments.

Comment: We received three comments regarding the DRG classification of major joint replacements of the lower extremity involving infections or mechanical complications, which are currently assigned to DRG 209. The commenters wrote to support the creation of a separate DRG for these cases, citing the August 30, 1991 final rule (56 FR 43205) where we stated that we intend to address this issue through our refinements to the DRG system to reflect variation in the severity of illness among patients. The commenters pointed out that since a handful of specialty hospitals treat a disproportionate number of these very complicated cases, they are being systematically underpaid under the present DRG classification.

One commenter submitted a report that analyzes the DRG 209 cases treated at one of these specialty hospitals and makes recommendations on how to reclassify certain DRG 209 cases to improve payment equity to these types of hospitals. The commenter believes that the type of severity adjustment HCFA is considering (that is, one in which consideration is given to a set of major complicating conditions applied across all DRGs) is not the type of system that will remedy the problem in DRG 209. The issue in DRG 209 is a type of severity problem in which a specific diagnosis or procedure represents a clinically meaningful subset of patients within a certain DRG that are more severely ill. Therefore, the commenter recommends creating new DRGs for replacement of infected prosthesis of the lower extremity and for mechanical and other complications of limb replacement of the lower extremity. In response to our request in the proposed rule for comments on methods for predicting the effect of DRG changes on coding and payment (see detailed discussion below in section II.D of this preamble), this commenter proposes a methodology and believes that the change he is seeking in DRG 209 could serve as the "field" test for the proposal.

Response: In general, we do not make DRG changes for a small subset of cases in a DRG that tend to have charges higher than average. Our response to requests for such changes is to point out the averaging effect of cases in a DRG. That is, in each DRG there are cases for which the costs are higher than average; however, there are also cases with costs lower than average, and the cases will,

over the long run, balance out. We consider making exceptions to this policy when the subset of higher cost cases is not spread over many hospitals but, rather, is concentrated in a few specialty hospitals. Based on the evidence we have seen so far, it appears that the distribution of these complicated joint replacements may be systematically underpaying a small number of hospitals that, because of their specialization, are unable to balance the expensive cases with a comparable number of less expensive cases.

Since we are unable to thoroughly evaluate this suggestion for a possible change in FY 1993, we will add this issue to our FY 1993 DRG analysis agenda.

5. Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders (MDC 20)

In response to concerns that the alcohol/drug DRGs needed further refinement, alcohol/drug treatment hospitals and distinct part hospital units were excluded from the prospective payment system soon after its implementation. This exclusion was temporary until an adjustment to the DRG classification system would permit prospective payment to be made appropriately for alcohol and drug treatment services.

Effective with discharges occurring on or after October 1, 1987, the alcohol/drug DRGs were restructured as follows:

- DRG 433 Alcohol/Drug Abuse or Dependence, Left Against Medical Advice
- DRG 434 Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, with CC
- DRG 435 Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, without CC
- DRG 436 Alcohol/Drug Dependence with Rehabilitation Therapy
- DRG 437 Alcohol/Drug Dependence, Combined Rehabilitation and Detoxification Therapy

Effective with the same date, the exclusion of alcohol/drug treatment hospital and units from the prospective payment system was eliminated, and these hospitals and units were brought under the prospective payment system. (For a detailed discussion of this change, see the June 10, 1987 proposed rule (52 FR 22081), the September 1, 1987 final rule (52 FR 33036), and the September 1, 1987 final notice on DRG classification changes (52 FR 33143).)

Since that time, we have received inquiries concerning the possibility of

adding a surgical partitioning to MDC 20. Based on our analysis of the FY 1991 MEDPAR data, we estimated in the proposed rule that the total number of cases in MDC 20 that would result in a surgical DRG assignment is under 1 percent. We did not believe that this was a sufficient number of cases to propose the creation of a surgical DRG.

However, a review of the average charges for the surgical cases shows that these cases tend to be much more expensive than the medical cases that group to MDC 20. In fact, the average charge for a case with an OR procedure more closely resembles the average charge of those cases classified to DRGs 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis), depending on the assignment procedure. Therefore, to ensure equitable payment and to accommodate surgeries performed during alcohol/drug admissions, we proposed that all cases classified in MDC 20 for which an OR procedure is performed would be assigned to DRG 468, 476, or 477 as appropriate, effective with discharges on or after October 1, 1992.

We received no comment on this change; thus, we are incorporating our proposal into this final rule.

6. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class "heart transplant" consists of a single DRG (DRG 103) and the class "coronary bypass" consists of two DRGs (DRGs

106 and 107). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class, therefore, involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5, and that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we will weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes will then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other OR procedures" as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPE searches for the procedure in the most resource-intensive surgical class, which may sometimes occur in cases involving multiple procedures, this result is unavoidable.

We would like to point out that, notwithstanding the foregoing discussion, there are a few instances where a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the "other OR procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs regardless of the fact that the weighting factor for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The "other OR procedures" class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the

hierarchy change, the weighting factors are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy for the pre-MDC DRGs and MDCs 3, 5, 8, and 12 as set forth below.

- In the pre-MDC DRGs, we proposed to reorder Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder (DRG 483) above Bone Marrow Transplant (DRG 481).

- In MDC 3, we proposed to reorder Myringotomy with Tube Insertion (DRGs 61 and 62) above Cleft Lip and Palate Repair (DRG 52) and reorder Sinus and Mastoid Procedures (DRGs 53 and 54) above Sialoadenectomy (DRG 50).

- In MDC 5, we proposed to reorder Amputation for Circulatory System Disorders Except Upper Limb and Toe (DRG 113) above Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure (DRGs 115 and 116) and to reorder Upper Limb and Toe Amputation for Circulatory System Disorders (DRG 114) above Cardiac Pacemaker (DRGs 117 and 118).

- In MDC 8, we proposed to reorder Foot Procedures (DRG 225) above Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223).

- In MDC 12, we proposed to reorder Testes Procedures (DRGs 338, 339, and 340) above Transurethral Prostatectomy (DRGs 336 and 337).

Comment: The only comment we received on the surgical hierarchy changes was from a national association representing children's hospitals regarding two of our proposed changes. The first comment concerned our proposal to reorder pre-MDC DRG 483, Tracheostomy, Except for Mouth, Larynx, or Pharynx Disorder, above DRG 481, Bone Marrow Transplant. The commenter states that, based on his review of data, the arithmetic mean costs for bone marrow transplant patients are the same or more than those for tracheostomy patients. He also suggests that, from a clinical coherence standpoint, it is advantageous to group bone marrow patients above the more heterogeneous tracheostomy grouping. The commenter, therefore, urges that we leave the pre-MDC hierarchy as it is currently.

In addition, the commenter is concerned about our proposal to reorder Myringotomy with Tube Insertion (DRGs 61 and 62) above Cleft Lip and Palate Repair (DRG 52). The commenter

reports that, for a pediatric population, patients are not often admitted for an inpatient stay just for a myringotomy, although there are a number who are admitted for other surgical procedures and also receive a myringotomy. In contrast, many pediatric patients are admitted for the more complex procedure of cleft lip and palate repair. If our hierarchy change is implemented, the commenter foresees a number of cases in which the child will be admitted to the hospital in order to have a cleft palate repair and a myringotomy, and the child will group to one of the myringotomy DRGs rather than the cleft lip and palate DRG.

Response: In our analysis of FY 1991 MEDPAR data, we determined that the average standardized charge for patients in DRG 483 is higher than that for the cases in DRG 481. Based on cases in the FY 1991 MEDPAR file, the average standardized charges for DRG 483 and 481 are \$115,093 and \$103,213, respectively. The commenter did not report which data were used for his analysis, but we have used consistently the same data (that is, the MEDPAR file) and methodology to make all changes to the surgical hierarchy. It is possible that the commenter has many more pediatric patients in his data than does MEDPAR and that that had an effect on his average costs. However, since the purpose of the surgical hierarchy is to ensure that Medicare cases with multiple surgical procedures are assigned to the Medicare DRG associated with the most resource-intensive surgical class, we are proceeding with this change.

Regarding the second comment about the reordering of DRGs 61 and 62 above DRG 52, we understand the commenter's concern. However, for the Medicare population, this ordering is more accurate than the current hierarchy. As we have stated in previous years, the changes we make to the prospective payment system, and the DRG classification in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and disabled. Therefore, changes and modification we make to that system may not always be appropriate for a younger population, such as the one treated most often in children's hospitals. With regard to the commenter's specific concern that this change in hierarchy would result in cases previously classified to DRG 52 now being classified in DRGs 61 and 62 because they have both procedures performed, based on our data, no cases moved from DRG 52 to 61 and 62 as a result of the hierarchy change. We also

note that we had previously proposed this change as a part of our FY 1991 changes and, in response to a similar comment, decided not to proceed with the change because of the small difference in average charges. (See the September 1, 1990 final rule; 54 FR 36025.) However, this year, the difference in average charges between these two surgical classes has increased so much we believe we must implement the change to ensure correct payment for the Medicare cases in these DRGs.

Based on a test of the proposed surgical hierarchy using the most recent MEDPAR file and the revised GROUPEER software, we find that the changes we proposed are still supported by the data and no additional changes are indicated. Therefore, the proposed surgical hierarchy is incorporated in this final rule.

7. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (CCs). This list was developed by physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In preparing the original CC list, a substantial CC was defined as a condition that, because of its presence with a specific principal diagnosis, would increase the length of stay by at least one day for at least 75 percent of the patients.

In previous years, we have made changes to the standard list of CCs, either the addition of new CCs or the deletion of CCs already on the list. For FY 1993, we did not propose to make any changes to the current CC list.

We proposed a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD-9-CM diagnosis coding system effective October 1, 1992. (See section II.B.9, below, for a discussion of these changes.) We proposed the changes in accordance with the principles established when we created the CC Exclusions List in 1987. In this final rule, we are implementing the changes as proposed.

Tables 6g and 6h in section IV of the addendum to this final rule contain the revisions to the CC Exclusions List that are effective for discharges occurring on or after October 1, 1992. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an

indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6g—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1992, the indented diagnoses will not be recognized by the GROUPEER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6h—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1992, the indented diagnoses will be recognized by the GROUPEER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for \$73.00 and on microfiche for \$19.00, plus \$3.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number, (PB) 88-133970), should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161; or by calling (703) 487-4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, and 1992) and those in Tables 6g and 6h of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1992.

Alternatively, the complete documentation of the GROUPEER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPEER program. The DRG Definitions Manual, Version 10.0, is available for \$195.00, which includes \$15.00 for shipping and handling. This manual may be obtained by writing 3M/HIS at: 100 Barnes Road, Wallingford, Connecticut 06492; or by calling (203) 949-0303.

Comment: Although we proposed no changes in our CC list, we received a comment from an association of children's hospitals concerning the CC list. The commenter notes that the CC list would be different if the Medicare DRGs were intended to serve a pediatric population and requested that we restate our explanation, published in the August 31, 1991 final rule (55 FR 43211).

of the intended patient population for the Medicare DRGs.

Response: In response to the commenter's request, we will restate the specified explanation. While we are aware of the fact that changes we make or do not make in the Medicare DRG system may have an impact on children's hospitals with regard to other payment systems that use our DRGs, the prospective payment system, and the DRG classifications in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and disabled. Therefore, changes and modifications we make to that system may not always be appropriate for a different population.

8. Review of Procedure Codes in DRGs 468 and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether, in conjunction with certain principal diagnoses, there were certain procedures performed that are not currently included in the surgical hierarchy for the MDC in which the diagnosis falls. In FY 1989, this review resulted in the addition of DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis) and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis). For a detailed discussion of these changes, see the September 30, 1988 final rule (53 FR 38487).

Since DRG 468 is reserved for those cases in which none of the OR procedures is related to the principal diagnosis, it is intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRGs 476 and 477 are assigned to specific subsets of these cases. DRG 476 is currently assigned to those discharges in which a prostatic procedure is performed that is unrelated to the principal diagnosis.

DRG 477 is assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD-9-CM procedure codes for the procedures we consider nonextensive procedures if performed with an unrelated principal diagnosis was published in Table 6c in section IV of the addendum to the September 30, 1988 final rule (53 FR 38591). As a part of the September 4, 1990 final rule, we moved a large number of procedures from DRG 468 to 477. We listed the procedure codes in

Table 6g in section IV of the addendum to that final rule (55 FR 36135).

We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. This year's review did not identify any changes that are necessary; therefore, we are not moving any procedures from DRGs 468 or 477 to one of the surgical DRGs.

We also reviewed the list of OR procedures that produce DRG 468 assignments to ascertain if any of those procedures should be moved to the list of nonextensive procedures that produce DRG 477 assignments. We analyzed the charge and length of stay data for cases assigned to DRG 468 to identify those procedures that are associated with discharges that are more similar to the discharges that currently group to DRG 477 than to the discharges that group to DRG 468. Generally, we consider moving only those procedures for which we have an adequate number of discharges to analyze the data.

Based on our analysis, we proposed to add the following four procedures to the list of nonextensive procedures that group to DRG 477:

- 04.41 Decompression of trigeminal nerve root
- 04.42 Other cranial nerve decompression
- 04.44 Release of tarsal tunnel
- 04.49 Other peripheral nerve or ganglion decompression or lysis of adhesions

These cases will group to DRG 477 instead of DRG 468 beginning with discharges on or after October 1, 1992.

We received no comments on our proposals for DRG 468 and 477. Therefore, we are incorporating these changes into the final DRG classifications.

9. Changes to the ICD-9-CM Coding System

As discussed above in section II.B.1 of this preamble, the ICD-9-CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD-9-CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD-9-CM. This includes approving coding changes,

developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has lead responsibility for the ICD 9-CM diagnosis codes included in Volume 1—Diseases: Tabular List and Volume 2—Diseases: Alphabetic Index, while HCFA has lead responsibility for the ICD-9-CM procedure codes included in Volume 3—Procedures: Tabular List and Alphabetic Index.

The Committee encourages participation in the above process by major health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding fields, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on May 2, August 1 and 2, and December 5 and 6, 1991 and finalized the coding changes after consideration of oral comments received at the meetings and written comments received in the 30 days following the December 1991 meeting. The initial meeting for consideration of coding issues for resolution in FY 1993 was held on May 7, 1992 and a second meeting concerning diagnosis codes only was held on August 4, 1992. Copies of the minutes of these meetings may be obtained by writing to the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Sue Meads, R.R.A., Co-Chairperson, ICD-9-CM

Coordination and Maintenance Committee, NCHS, Rm. 9-58, 8525 Belcrest Road, Hyattsville, Maryland 20782.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, HCFA, Office of Coverage and Eligibility Policy, Rm. 401 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

The ICD-9-CM code changes that have been approved will become effective October 1, 1992. The new ICD-9-CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD-9-CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

Further, the Committee has approved the expansion of certain ICD-9-CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or have been deleted are in Table 6c (Invalid Diagnosis Codes). Procedure codes that have been replaced by expanded codes or have been deleted are in Table 6d (Invalid Procedure Codes). These diagnosis and procedure codes will not be recognized by the GROUPE beginning with discharges occurring on or after October 1, 1992. The corresponding new expanded codes are included in Tables 6a and 6b. Revisions to diagnosis and procedure code titles are in Tables 6e (Revised Diagnosis Code Titles) and 6f (Revised Procedure Code Titles), which also include the proposed DRG assignments for these revised codes.

No comments were received on our proposed DRG assignments for new and revised ICD-9-CM codes.

10. Other Issues

a. Cochlear Implants

Comment: We received two comments strongly urging us to reassign multi-channel cochlear implants from DRG 49 (Major Head and Neck Procedures) to a new DRG. The commenters noted that this issue has been brought to HCFA's attention every year since 1986 with no change in DRG classification. In the commenters' opinion, classification to DRG 49 vastly underpays these cases, resulting in large losses to hospitals and possible disincentives for hospitals to

provide this service to Medicare beneficiaries. This year's proposed reduction in relative weight for DRG 49 (from 2.2790 in FY 1992 to 1.6364 in the proposed rule) will further reduce hospital payment.

One of the commenters commissioned an independent study on payment for cochlear implants and included the report from that study in the comment. This study identified 100 cochlear implant cases in the FY 1991 MEDPAR file assigned to DRG 49. Of that number, 14 cases were from hospitals that had not purchased the cochlear implant device from the only company in the United States that manufactures the devices. An additional 34 claims had billed charges less than \$17,000, which the commenter believes is a minimum charge for one of these cases. This minimum charge is based on the cost of the device (approximately \$14,695) and the resources consumed by a 2-day hospital stay. These cases were identified as "misbilled" in the study.

The study calculated that the remaining 52 correctly coded and billed cochlear implant cases had average standardized charges of \$23,489. The report concluded with four alternative recommendations:

- Reassign cochlear implant procedure codes to DRG 1 (Craniotomy Age > 17 Except for Trauma), which has a proposed weight of 3.2349.
- Reassign cochlear implant procedures to a new DRG within MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) and assign a payment weight of 3.3785.
- Reassign the less costly cases (that is, virtually all cases other than cochlear implants) from DRG 49 to DRG 63 (Other Ear, Nose, Mouth and Throat OR Procedures).
- Allow separate Part B Medicare payment for the external components of the cochlear implant system.

Response: We have previously addressed the issue of cochlear implants, most recently in the prospective payment final rule for FY 1991 published on September 4, 1990 (55 FR 36029). Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49, which is the highest weighted surgical DRG in MDC 3. Since that time, the cochlear industry has contended that the weight of DRG 49 is too low and does not adequately reflect the resources necessary for cochlear implant.

In response to these most recent comments, we analyzed the FY 1991 MEDPAR data for DRG 49 to determine the current charges and length of stay for cochlear implants. The ICD-9-CM procedure codes we used to identify

these cases are 20.96 (Implantation or replacement of cochlear prosthetic device, NOS), 20.97 (Implantation or replacement of cochlear prosthetic device, single channel), and 20.98 (Implantation or replacement of cochlear prosthetic device, multiple channel). We found no cases coded with 20.97 (Single channel devices) and, in fact, these devices have been replaced by the multi-channel devices and are no longer available.

In reviewing the FY 1991 data, we identified 100 cochlear implant cases (the same number identified by the independent study). These cases had an average charge of \$17,135, compared to an average charge of \$11,696 for all other cases in the DRG. This is a change from the last analysis we did using FY 1989 MEDPAR data. At that time, the average charge for cochlear implants cases was \$13,338. The average charge for all other cases in DRG 49 was \$15,680. However, cochlear implant cases currently comprise only 3.4 percent of the total DRG 49 cases (100 out of 2,963). We also note that, although the number of cases increased from 69 in FY 1987 to 113 in FY 1988, they have been decreasing since then with 107 cases in FY 1989 and 100 in FY 1991.

Although the average charge for cochlear implants has increased, the charge we have calculated based on FY 1991 MEDPAR data is still much lower than the charge calculated by the study. This is because we have included in our calculation all the cases in the FY 1991 MEDPAR file with a cochlear implant procedure code. The study excluded almost one-half of the cases (48 out of 100) because they believe they were miscoded or misbilled. We have previously addressed this problem and, in fact, we issued instructions to the Medicare Part A fiscal intermediaries (Transmittal No. 1525, May 1991) and the Part B carriers (Transmittal No. 1393, May 1991) concerning this issue. The intermediaries were instructed to return to the hospital any claim for cochlear implants where total charges are less than \$17,000. The hospitals are instructed to review and verify the procedure codes and total charges. The carriers are instructed to deny charges under Part B for speech processors furnished in support of surgery during an inpatient hospital stay. We believe that these steps should assist in improving the MEDPAR data on cochlear implants.

In the meantime, while there is a higher charge for the 100 cochlear cases than for the noncochlear cases in DRG 49, we note that the cases are distributed across 53 hospitals and the highest volume of cases at any one

hospital is only 8. There are only 10 hospitals with 3 or more cases; 4 with 6 or more. Charges per case range from \$1,235 to \$32,951. Length of stay is quite low, with many patients staying in the hospital for only one day.

In response to the recommendation submitted by the commenters to assign cochlear implant cases to a new DRG with a weight of 3.3785, we believe the process for calculating DRG relative weights needs to be clarified. HCFA does not assign weights to DRGs arbitrarily, but, rather, calculates the weight for each DRG based on the resources necessary to treat patients assigned to that DRG relative to all other DRGs. A DRG weight cannot be adjusted or a new DRG created without affecting the weight of other DRGs. It would be inappropriate and inadvisable for us to create a new DRG with a specified weight assigned, as such action would impact the weight and, therefore, the payment, for other DRGs. The process by which DRG weights are recalibrated is described in detail below in section II.C. of this preamble. The weight for DRG 49 in Table 5 reflects both decreases in the charges submitted for the case assigned to DRG 49 and increases in charges for other DRGs, causing a redistribution of the relative weights and resulting in a lower weight for DRG 49.

As discussed above, the reported study recommends several options for resolving the perceived payment inequities for cochlear implants. First, the study suggests moving cochlear implant procedure codes to DRG 1. However, the diagnosis code category assigned to patients admitted for cochlear implants is 389 (Hearing loss). These diagnosis codes are assigned to MDC 3. As noted above in section II.B.1 of this preamble, except for a few special cases, principal diagnosis determines MDC assignment and each code is assigned to a unique MDC. The commenter suggests we handle this problem in the same manner that liver and bone marrow transplant cases are classified, which is by using the procedure codes instead of diagnosis codes for assignment. Liver and bone marrow transplant cases are not assigned to any MDC but are classified by procedure to DRG 480 (Liver Transplant) and DRG 481 (Bone Marrow Transplant) prior to MDC assignment. These DRGs are structured in this way because liver and bone marrow transplants are performed for patients who have principal diagnoses that are assigned to more than one MDC. Therefore, the only way to create one DRG for the procedure and to assign all

the appropriate cases to the DRG is to place it before the MDC assignment step.

This method would not be appropriate for cochlear implants. To move these cases to DRG 1, we would have to move the principal diagnosis code category 389 from MDC 3 to MDC 1 (Diseases and Disorders of the Nervous System). However, based on clinical coherence, code category 389 is correctly placed in MDC 3. We note that heart transplant cases are assigned only to MDC 5 (Diseases and Disorders of the Heart) because they are performed only on patients with principal diagnoses assigned to that MDC. Not only would moving cochlear implants to DRG 1 be clinically indefensible, it would also result in significant overpayment to the 100 cochlear cases, which have an average charge of \$17,135 compared to the average charge for the cases in DRG 1 of \$22,598.

As noted by the commenter, DRG 49 is the highest weighted DRG in MDC 3. Therefore, there is no other DRG conveniently available for assignment of cochlear implants. We believe that the low volume of these cases does not justify the establishment of a new DRG specific to cochlear implants, nor do we generally create DRGs that are specific to a single technology, especially those available only through a single source manufacturer. Assigning less costly cases from DRG 49 to DRG 63, as also suggested by the commenter, would produce the same result, a separate DRG for a small number of technology-specific cases, and would underpay the noncochlear DRG 49 cases (average charge \$11,789) relative to other cases in DRG 63 (average charge \$7,291). We also note that DRG 63 is the "Other OR procedures" class for MDC 3. This is a group of procedures that are the least likely to be related to the diagnoses assigned to MDC 3, but are occasionally performed on patients with these diagnoses. The procedures assigned to DRG 49 are specifically related to the MDC 3 diagnoses and should not be reassigned to a catchall DRG.

Finally, the commenter states that a substantial portion of the hardware cost of cochlear implant devices is for the externally worn components, the speech processor and headset, which are typically provided to the patient 4 to 6 weeks after the surgery. This commenter suggests these costs be "unbundled" from other inpatient supplies and services and be billed by the surgeon or audiologist to part B Medicare. Since the short length of stay incurred by these patients (70 percent of the admissions in the FY 1991 data had a length of stay of

only 1 or 2 days) indicates that the cost of the device is the major component of the charges, allowing this practice would substantially lower the average charge for these cases.

Prior to implementation of the prospective payment system, it was a practice for certain nonphysician services and supplies furnished to hospital inpatients to be billed directly to patients under part B of the program. However, with the enactment of Public Law 98-21 and the implementation of the prospective payment system, several statutory changes concerning the bundling policy were made. More specifically, section 1862(a)(14) of the Act provides that, to qualify for Medicare payment, all services (with limited exceptions) furnished to hospital inpatients must be provided directly or arranged for by the hospital. Thus, these services become inpatient hospital services payable under part A. Section 1833(d) of the Act, in turn, requires that services that are payable under part A may not be paid for under part B. Therefore, all the services provided to a Medicare beneficiary as part of the inpatient hospital stay are covered under part A and may not be billed under part B. This includes the external components of the cochlear device that is implanted during an inpatient stay covered under part A. Therefore, we cannot allow separate part B payment for part of the cochlear device.

We acknowledge that the payment for cochlear implant patients has been an issue for several years. We will continue to evaluate the payment for these cases and its impact on hospitals.

b. HIV-Related Conditions

Comment: We received three comments urging HCFA to adopt the newly identified conditions that are considered by the Centers for Disease Control (CDC) to be HIV-related. The commenters state that these conditions should be included in the list of "major related conditions" as soon as practicable after they are identified to allow these cases to group to DRG 489 (HIV with Major Related Condition).

Response: As we stated in the September 4, 1990 final rule (55 FR 36019) and the August 30, 1991 final rule (56 FR 43208), the HIV-related conditions that qualify for classification to MDC 25 (HIV Infections) are limited to those conditions identified by CDC as being HIV-related. This process includes listing these conditions in Volume 1 of ICD-9-CM in the "Includes Only" notes under diagnosis codes 042.0, 042.1, 042.2, 043.1, 043.3, and 044.0. Since we

established the HIV DRGs effective with discharges in FY 1991, we have worked with the National Center for Health Statistics (NCHS), CDC to ensure that our classification of HIV patients is as current and inclusive as possible. In response to this comment, we again contacted NCHS to ensure that our list of HIV-related conditions is complete. Although CDC has reported that new diagnoses are occurring with increasing frequency within the HIV-infected population, these diagnoses have not yet been added to the list of HIV-related conditions. When they are, we will incorporate them into our next list of conditions for MDC 25.

We note that whether these conditions will be considered "major" will be determined by the nature of the condition. Using our criteria, a major HIV related condition involves a disease or disorder of the central nervous system, a malignancy, an infection, or other major related condition.

c. MCE Age Conflict Edits

Comment: We received two comments concerning certain age conflict edits in the MCE. Currently, the MCE identifies and rejects for further development claims that include codes for congenital conditions for patients who are no longer in the newborn age period. However, as stated in the November-December 1986 issue of Coding Clinic for ICD-9-CM, it is correct to report congenital conditions as principal diagnoses for patients beyond the newborn stage. The commenters recommend that, while it may be appropriate to edit for these conditions in the Medicare population, recoding of the cases should not be required and cases should be grouped and paid by the fiscal intermediary once the accuracy of the coding has been verified.

Response: The purpose of the MCE is to identify cases that may require further review due to questionable information on the Medicare claim, and a case that lists a diagnosis that is unlikely in a patient of a certain given age is considered questionable. However, all edits in the MCE can be overridden by the fiscal intermediary once it has verified the correctness of the claim. Although some edits should never be overridden (for example, a noncovered procedure edit or a sex conflict edit), most of the age edits may be occasionally overridden after verification of the claim. We believe the reason that the commenters are experiencing trouble recently is not due to the actions of the fiscal intermediaries, but rather the fact that the HCFA Common Working File (CWF), through which all Medicare

inpatient hospital claims must pass before payment, does not provide a mechanism to override MCE edits. We agree with the commenters that Medicare payment should be made for claims that have been coded properly based on coding principles and instructions. Therefore, we will pursue revising the current data edits in the CWF to allow payment for correctly coded claims.

d. Lung Transplants

Comment: We received three comments requesting that immediate consideration be given to recognizing single and double lung transplants as approved, covered Medicare services and creating one or more new DRGs specifically for these cases. One of the commenters (a consulting firm writing on behalf of the other two commenters) submitted an analysis of the cost of these cases and asserted that the payment currently being made for these cases under the prospective payment system is inadequate. In addition, the commenter submitted a recently completed evaluation of the risks, benefits, and clinical effectiveness of lung transplants prepared by the Office of Health Technology Assessment, Agency for Health Care Policy and Research, HHS. ("Single and Double Lung Transplantation", Health Technology Assessment Reports, 1991, Number 5, May 1992, Pub. No. 920028.)

Response: Currently, lung transplants have not yet been the subject of a national coverage decision. Therefore, under HCFA policy, the Medicare contractors (that is, the Part A fiscal intermediaries and the Part B carriers) determine whether or not to cover and pay for claims associated with a lung transplant. Under the current DRG classifications, ICD-9-CM procedure code 33.5 (Lung transplant) is assigned to DRG 75 (Major Chest Procedures) in MDC 4 (Disease and Disorders of the Respiratory System). We note that combined heart-lung transplants (procedure code 33.6) are not covered under Medicare as provided in the notice of HCFA ruling that extended coverage to heart transplants, which was published in the Federal Register on April 6, 1987 (52 FR 10936).

HCFA has begun exploring the possibility of covering lung transplants on a national basis. However, based on our recent experience with other transplant coverage decisions, we believe this process could take a year or more to complete. As part of that process, we will also consider the appropriateness of establishing a new DRG for these cases. We will consider the commenters' suggestions as a part of

this determination. We note that any classification of lung transplants, and the resulting DRG relative weight, will be based, to the extent possible, on the cost of providing this service to Medicare beneficiaries.

e. Classification of Vascular Device Infections

Comment: We received a comment requesting that consideration be given to moving ICD-9-CM diagnosis code 996.62 (Infection and inflammatory reaction due to other vascular device, implant and graft) from DRGs 144 and 145 (Other Circulatory System Diagnoses) to DRG 416 and 417 (Septicemia). The commenter states that patients with vascular devices are prone to developing septicemia as a result of the device. However, coding rules require that the complication code (996.62) be coded as the principle diagnosis and the code for septicemia be a secondary diagnosis. (Coding Clinic for ICD-9-CM, Second Quarter 1990, PDX #15.) This results in the patient being classified to DRGs 144 and 145, with proposed weights of 1.0691 and .6304, respectively. A septic patient whose condition is not attributed to the presence of a vascular device will group to DRG 416, with a proposed weight of 1.5203. Therefore, the commenter believes we should consider changing the DRG assignment for code 996.62.

Response: The commenter is correct in stating the applicable coding rules. When the admission is for the treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 966 through 999 series, an additional code for the specific complication may be assigned. Thus, the case as described by the commenter is correctly coded with 996.62 as the principal diagnosis and the applicable diagnosis code for septicemia from the 038 series as secondary.

According to our medical consultants, patients with vascular devices rarely develop septicemia that is attributable to the presence of the device. It is much more likely that the septicemia is not related to the device. The attending physician is responsible for stating in the medical record the relationship between the septicemia and the presence of the medical device. However, if the case described by the commenter does occur, it is correctly placed in DRGs 144 and 145, which are located in MDC 5. We note that all the complication codes associated with devices of the circulatory system are assigned to these DRGs. It would be

inappropriate to place these codes in MDC 18 (Infectious and Parasitic Disease (Systemic or Unspecified States). Code 996.62 is neither a systemic or unspecified infection and is clinically coherent with the other MDC 5 diagnoses. Therefore, we do not intend to move it to any other MDC.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 1993 recalibration as we did for FY 1992. That is, we proposed to recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 1991 MEDPAR file, rather than the FY 1990 MEDPAR file. The MEDPAR file is based on fully coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights were constructed from FY 1991 MEDPAR data, received by HCFA through December 1991, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1991 MEDPAR file at that time included data for approximately 10.2 million Medicare discharges. The MEDPAR file updated through June 1992 includes data for approximately 10.4 million discharges and this is the file used to calculate the weights set forth in Table 5 of the addendum to this final rule.

The methodology used to calculate the DRG relative weights from the FY 1991 MEDPAR file is as follows:

- All the claims were regrouped using the revised DRG classifications discussed above in section II.B of this preamble.

- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.

- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated.

- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average standardized charge per case to determine the weighting factor.

- We established the weighting factor for heart transplants (DRG 103) and liver transplants (DRG 480) in a manner consistent with the methodology for all other DRGs except that the heart and liver transplant cases that were used to establish the respective weight were limited to those Medicare-approved heart and liver transplant centers that have cases in the FY 1991 MEDPAR file.

- Acquisition costs for kidney, heart, and liver transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); and DRG 480 (Liver Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In the FY 1990 MEDPAR data used to establish the FY 1992 weights, there were 37 DRGs that contained fewer than 10 cases. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1993. Using the FY 1991 MEDPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weight for the 37 low-volume DRGs by adjusting the original weights of these DRGs by the percentage change in the average weight of the cases in the remaining DRGs.

The weights developed according to the methodology described above, using the DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that reclassification and recalibration changes beginning with FY 1991 be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made

without the changes. We interpret section 1886(d)(4)(C)(iii) of the Act to require that we ensure the FY 1993 reclassification and recalibration changes do not affect aggregate payments. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals. Therefore, as discussed in section II.A.4.b of the Addendum to this final rule, we are making a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Comment: We received one comment recommending that Medicare exclude the low-volume DRGs from the prospective payment system. The commenter stated that, because the FY 1993 weights for these DRGs were set by applying the average increase in the case-mix index across all cases to the FY 1992 weights for these DRGs, the weights no longer reflect the resources used to treat patients in these DRGs. The commenter notes that all but three of these DRGs are for pediatric (the age 0-17 category) or neonatal cases. These "artificial" weights have a minor impact on payments under Medicare but may result in severe distortions in payments for other populations for whom the Medicare weights are used. Therefore, HCFA should refrain from calculating and publishing weights for these DRGs.

Response: As described above, the weight for every DRG with fewer than 10 cases was computed by adjusting the DRG's original weight by the percentage change in the average weight of the cases in the remaining DRGs. Increasing the weight by the percentage change in the average case weight maintains a constant relationship between the average resources required for these cases and the average Medicare case. We believe that this is a reasonable approach to establishing the relative weight when there are insufficient cases to calculate the weight based on current charge data. The original weights for the low volume DRGs were calculated by supplementing the MEDPAR data with records from Maryland and Michigan. (See the September 1, 1983 final rule with comment period (48 FR 39768).) There were 109 DRGs whose weights were calculated in this manner. We note that there have been fewer than 40 low-volume DRGs for several years and that these DRGs vary somewhat from year to year. In addition, although low volume, cases continue to be classified to these DRGs. It would be inappropriate to

exclude the low volume DRGs from the prospective payment system because we have no other basis for paying the cases that are classified to these DRGs.

In response to the concern that others who use the Medicare weights may experience distortions in payments due to the presence of these low volume DRGs, we reiterate that the DRG weights set forth in this final rule are established for the Medicare population. While other payers may wish to follow the Medicare classification scheme, we have consistently cautioned against the use of Medicare DRG weights for other populations.

Comment: One commenter examined the impact of the proposed DRG weights for the top 58 high volume DRGs at his hospital. Based on this analysis, the commenter notes that payments to his hospital will decrease dramatically. The commenter protests a loss in payment that is attributable only to recalibration, further reducing overall payments to hospitals already suffering from the effects of the recession.

Response: Each year, as directed by section 1886(d)(4)(C) of the Act, we recalibrate the DRG weights to accurately reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The DRG weights are not arbitrarily set by HCFA, but rather are calculated based on the actual case charges submitted by hospitals.

Because the DRG weights are relative to each other, it is impossible for weights to increase for all DRGs. As some increase, others must decrease. In the past few years, average charges in the more resource-intensive DRGs have tended to rise more rapidly than those in the less resource-intensive DRGs. As a result, those hospitals that tend to treat cases that are assigned to the more resource-intensive DRGs will realize an overall increase in payments due only to the recalibrated weights (regardless of any update factor applied to the standardized amounts), whereas hospitals that tend to treat cases in the less resource-intensive DRGs will realize an overall decrease in payments. Reclassification and recalibration are intended to reflect changes in relative resource costs and to distribute the payments made to all hospitals under the prospective payment system in the most equitable way possible based on the types of cases the hospitals treat.

D. FY 1991 DRG Classification Changes and Their Effect on DRG Relative Weights and Payments

As described above in sections II.B and C of this preamble, each year we

make changes to the DRG classifications in addition to recalibrating the relative weights based on the most recent charge data available. In the September 4, 1990 final rule, we made several major modifications to the DRGs effective with discharges occurring on or after October 1, 1990 (FY 1991). These changes included creating two new DRGs for liver and bone marrow transplants, which had recently been approved for coverage under the Medicare program. In addition, we added two DRGs for cases in which a tracheostomy is performed: one for patients with a disorder of the mouth, larynx, or pharynx and one for all other patients. Cases are assigned to these four DRGs prior to assignment to one of the MDCs.

We also added two new MDCs, one for multiple significant trauma (MDC 24) and one for human immunodeficiency virus (HIV) infections (MDC 25). MDC 24 consists of four DRGs (three surgical and one medical) and MDC 25 is made up of three DRGs (one surgical and two medical).

The FY 1991 changes were designed to improve payment equity by increasing the amount of variation in resource costs explained by the DRGs. For the most part, these new DRGs have extremely high weights, and the cases that are now classified to them receive much higher payments than they would have absent the changes.

When changes in DRG classifications are made, we account for the effect the changes will have on future program payments through the recalibration and normalization of the DRG weights. In the year in which the changes are effective, they are intended to be budget neutral; that is, the payments in that year should be no more or no less than the payments would have been without the changes. As discussed in more detail above, in Section II.C of this preamble, recalibration is accomplished by processing the most recent, complete MEDPAR data through a revised GROUPE that encompasses the DRG classification changes and reweighting the DRGs based on the charges submitted by the hospitals. After recalibration is complete, the new weights are normalized by an adjustment factor. The normalization process compares the average case weight before recalibration to the average case weight after reclassification and recalibration using the same set of MEDPAR data, and an adjustment is made to the new weights so that these two average case weights are the same.

When we conducted the normalization of the FY 1991 DRG weights, we used the FY 1989 MEDPAR

data. The FY 1989 claims were first mapped into their FY 1990 equivalents and processed through the FY 1990 GROUPE to determine the average case weight for that year. Those same data were then remapped into their FY 1991 equivalents and processed through the FY 1991 GROUPE to estimate what would be the average case weight during that year. The new DRG weights were then adjusted so that the two average case weights (FYs 1990 and 1991) are equal. (In addition to this process, we also made a budget neutrality adjustment to ensure that aggregate payments made in FY 1991 would be no more than and no less than they would have been absent the DRG and wage index changes.)

Now that the MEDPAR file for FY 1991 is available, we can evaluate the effect of the new DRGs on the actual distribution of cases under the revised DRGs. We find that many more cases than we had originally estimated were classified into the new DRGs. In addition, there are many DRGs that experienced at least a 20 percent increase or decrease in percentage of cases assigned between FY 1989 and FY 1991 when both sets of cases are grouped using the FY 1991 GROUPE. These include several of the new DRGs, other DRGs that were revised effective with FY 1991, and some DRGs for which there was no major change.

Based on our analysis of the MEDPAR received by HCFA through December, 1991, the effect of these unanticipated changes in the distribution of cases and the resulting increase in average DRG weight resulted in a 1 percent increase in Medicare inpatient hospital program payments compared to the payments that would have resulted if we had not made DRG reclassification and recalibration changes in FY 1991. If we had been in possession of the actual FY 1991 cases when we established the weights for FY 1991, the overall average case-mix index would have been 0.99 percent lower than the actual FY 1991 case-mix index. The total case-mix change between FY 1990 and FY 1991 was 2.5 percent.

Although there can be many reasons for increases in the relative number of cases assigned to a particular DRG, including an increase in the frequency with which procedures are performed or an increase in inpatient treatment of certain diagnoses, we believe that the 1 percent increase attributable to the DRG classification and recalibration changes was, for the most part, caused by coding improvements made in response to the FY 1991 DRG changes. The increase in cases assigned to higher-weighted DRGs

is most dramatic in the new tracheostomy DRG 483 and the three new HIV-related DRGs (488 through 490). When the FY 1989 and 1991 cases

are separately classified using the FY 1991 GROUPE, the number of cases assigned to DRG 483 increases 30 percent between the 2 years and the

number of cases assigned to DRGs 488 through 490 increases by 123 percent.

The following table illustrates the changes:

DRG	Number of cases in DRG		DRG cases as percent of total cases		Percent increase
	Estimate	Actual	Estimate	Actual	
483.....	25,191	32,751	0.25	0.32	30
488.....	261	473	.003	.005	81
489.....	1,801	4,187	.02	.04	133
490.....	780	1,679	.01	.02	115
Total MDC 24.....	2,842	6,334	.03	.06	123
Total cases.....	28,013	39,085	.28	.38	40

As noted above, we believe that the increases in the tracheostomy and HIV DRGs are due, in large part, to the fact that hospitals changed their coding practices between FYs 1989 and 1991 in response to the FY 1991 DRG changes. Before implementation of the FY 1991 changes, there was no incentive to code a tracheostomy outside of MDC 4 nor

was there any incentive to code a secondary diagnosis of HIV.

However, once these codes became significant for correct DRG classification, they were included on claims where they might previously have been left off.

Based on our analysis of the FY 1989 MEDPAR, in setting the FY 1991 relative weights, we estimated that 55 percent of

the cases reassigned to DRG 483 would have been classified to DRG 474 (Respiratory System Diagnoses with Ventilator Support) in MDC 4 before the FY 1991 changes. However, the actual number of cases reassigned from DRG 474 was lower while the number of cases reassigned from all other DRGs increased dramatically. The following table demonstrates these changes:

BREAKDOWN OF CASES ASSIGNED TO DRG 483 IN FY 1991

FY 1989 DRG	Estimate		Actual	
	Number of cases	Percent of DRG 483 cases	Number of cases	Percent of DRG 483 cases
DRG 474.....	13,929	55	11,851	36
All other DRGs.....	11,262	45	20,900	64
Total.....	25,191	100	32,751	100

This indicates that a significant number of cases assigned to other DRGs in the FY 1989 MEDPAR did not include a code for a tracheostomy procedure that was performed during the stay. Because DRG 483 had such a high relative weight in FY 1991 (14.0597) compared to the DRGs from which these cases were reclassified, the inability to predict correctly the actual case distribution resulted in a substantial unanticipated increase in program payments.

The new DRGs created for HIV cases experienced a similar influx of cases. In this case, the actual FY 1991 cases came from the DRGs we had predicted they would; however, they came in much larger numbers than we had estimated. For example, based on our analysis of the FY 1989 MEDPAR, we predicted that 21 percent of the cases reassigned to DRG 489 (HIV with Major Related Condition) would have been assigned to DRG 79 (Respiratory Infections and Inflammations with CC) absent the

reclassification. The actual percentage of FY 1991 cases assigned to DRG 489 that would have been assigned to DRG 79 remained virtually constant at 22 percent. However, the estimated number of cases was 385 and the actual number was 922. Therefore, even though we correctly predicted the percent of cases in DRG 489 that would move from DRG 79, the number of cases more than doubled. While we recognize the incidence of HIV increased between FY 1989 and 1991, we believe a 123 percent increase must also be attributable to improved coding for HIV infection.

This type of change in coding happens every year in response to DRG changes. One example of such a change is the deletion of diagnoses from the list of CCs. When CCs are present in a case, hospitals will make sure to code at least one CC in order to classify a case in the higher-weighted "with CC" DRG. However, if that CC is deleted from the list of recognized CCs for the DRG and we predict that the case will now be

classified in the non-CC DRG, it is possible that hospitals will simply code another CC present in the medical record in order to achieve the "with CC" classification. Therefore, cases that we had predicted would be classified to the "without CC" DRG actually remain as CC cases because of a change in coding.

Based on the FY 1989 MEDPAR, we had estimated that CC revisions effective for FY 1991 would change the distribution of cases in DRGs 320 and 321 (Kidney and Urinary Tract Infections Age > 17) by decreasing the number of cases assigned to DRG 320 (with CC). (The number of cases assigned to DRG 321 was estimated to remain about the same.) However, the actual number of cases assigned to DRG 320 in the FY 1991 MEDPAR file increased and the number of cases assigned to DRG 321 decreased. The number of cases assigned to DRGs 320 and 321 and their percent of total MEDPAR cases are shown below:

	Relative weight	Estimate		Actual	
		Number of cases	DRG cases as percent of total cases	Number of cases	DRG cases as percent of total cases
DRG 320.....	1.0055	145,039	1.47	162,874	1.60
DRG 321.....	.6507	34,523	.38	26,718	.28

Thus, the actual number of cases assigned to the higher-weighted DRG was higher than the number we had estimated, and the actual number of cases assigned to the lower-weighted DRG was lower. The coding practice changes made in response to our reclassification of CCs resulted in additional program payments beyond those we had estimated.

This can also happen in response to surgical hierarchy changes or to changes in the procedures that affect classification. This can be seen in the movement of cases in MDC 5 between FYs 1989 and 1991. We completely reconstructed the majority of the surgical DRGs in MDC 5 effective for FY 1991 and there were significant deviations from the estimated frequency for each DRG. For example, the changes made in MDC 5 for FY 1991 resulted in a tremendous increase of cases coded with percutaneous cardiovascular procedures. We assigned these cases to DRG 112 effective with FY 1991 and, based on the FY 1989 MEDPAR, we estimated that 83,614 cases would group to this DRG. The FY 1991 MEDPAR as of December 1991 shows that 128,778 cases were assigned to this DRG, an increase of 54 percent. Although this is the DRG that changed the most in terms of number of cases, virtually all of the revised MDC 5 DRGs experienced some change in the number of cases assigned in FY 1991 as opposed to our estimates.

Even though we have experienced this type of case-mix increase before (see the September 1, 1989 final rule for a discussion of the inflationary effect of the FY 1987 DRG changes (54 FR 36469)), we are particularly concerned about this problem in light of the fact that we are seriously considering major changes to the DRG system to better explain the effects of severity of illness. Besides the mandate of section 1886(d)(4)(C)(iii) of the Act, which provides that aggregate payments may not be affected by DRG reclassification and recalibration changes, we do not believe it is prudent policy to make changes for which we cannot predict the effect on the case-mix index and, thus, payments.

Although we can predict that changes in certain hospital coding practices may result from DRG changes we make, it is

not possible to predict which claims will be affected by these changes. Thus, in the reclassification and recalibration process, we can rely only on the code information included on actual cases. We are hoping that the expansion of the hospital bill to include nine diagnosis and six procedure codes will help to alleviate this problem to some extent. However, this change went into effect on April 1, 1992 and, thus, will not be reflected in a full year of MEDPAR data until FY 1993, which means it will not be available to us for purposes of weight construction until FY 1995.

As we stated in the proposed rule, we are strongly committed to making changes in the DRG system to improve payment equity; however, in light of the mandate of budget neutrality, our current inability to predict the changes in coding behavior that may result from our revisions limits the extent to which we can revise the system. Thus, we announced in the proposed rule that, until such time as we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG classification changes may have on coding behavior or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments, we intend to make only relatively insignificant changes in the DRG classification system. As a general policy, we will consider the changes to be insignificant if, in the aggregate, we estimate that program payments will increase by less than 0.1 percent if we have underestimated by 10 percent the number of cases that will receive more favorable payment under the DRG classification changes that provide incentives for coding improvement.

This general policy will preclude our making significant refinements to the DRG system until we are able to protect program payments against the inflationary impact of those changes. We emphasize that we will continue to make certain DRG reclassification changes that are appropriate. In fact, as discussed above in section II.B of this preamble, we are implementing changes in this final rule to reflect changes in relative resource use. The limitation on

making DRG classification changes applies only to significant modifications to the system.

One approach to this problem that we have considered is maintaining the average case weight at 1.0 after recalibration, thereby eliminating the process of normalization. In other words, after recalibration, we would not scale the new weights upward to carry forward the cumulative effects of past case mix increases. We would, instead, make an adjustment or include in the annual update factor a specific allowance for any real case-mix change that occurred during the previous year. This is a relatively simple and straightforward system for preventing the effects of year to year increase in case mix index from accumulating in the DRG weights.

This methodology would have several advantages. First, it would be an easy and effective means of removing from the payment base inappropriate year-to-year case-mix increase (that is, case-mix increases mainly due to changes in coding practices). It would also streamline the current process of adjustments, where recalibration of the weights is followed by normalization, and the recommended update factor includes a negative adjustment to offset all case-mix increase estimated for the previous year followed by a positive increase to add back the real case-mix increase (that is, a genuine increase in the resources required to treat patients). Finally, the change would restore the meaning of the relative weights by bringing the average weight back to 1.0 each year. Thus, 1.0 would reflect the average resources used to treat the average Medicare inpatient hospital case, while a weight of 2.0 would reflect a case that requires twice the average resources to treat and a weight of 0.5 would reflect a case that requires one-half the average resources. Since the final estimated average FY 1991 DRG relative weight is 1.3647, this type of comparison is not readily accomplished using normalized DRG relative weights.

We solicited public comments on this and other possible approaches that could be implemented to account for coding changes that result from

revisions in the DRGs. These comments and our responses are presented below.

Comment: One commenter protested our decision to do only minor recalibration of the DRG weights. The commenter believes that the result of this action is to keep payments artificially low for many of the higher-cost DRGs.

Response: We believe that this commenter misunderstood what we stated in the proposed rule. We intend to fully recalibrate the DRG weights every year based on the most recent MEDPAR data. We intend to limit only the extent to which we will make changes to the classification of cases into DRGs.

Comment: Many commenters objected to our decision not to make significant revisions in the DRGs until we improve our ability to predict the results of those changes or until we have made methodologic changes in the recalibration or in the determination of the annual update factor applied to the standardized amounts. The commenters urged us to adhere to the requirements of section 1886(d)(4)(C)(i) of the Act, which mandates annual revisions to the DRG classifications to reflect changes in resource use. The commenters believe that HCFA's current inability to account for the impact of DRG classification changes does not relieve the agency, legally or logically, of its statutory obligation to make all appropriate changes on an annual basis.

Response: We acknowledge our obligation to make appropriate DRG classification changes and to recalibrate DRG relative weights as mandated by section 1886(d)(4)(C) of the Act. In accordance with this provision, as the DRG reclassification changes set forth in this final rule demonstrate, we will continue to make changes to the DRGs to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Our decision to limit our changes is not an attempt to circumvent our statutory obligation. On the contrary, we are making every effort to improve our ability to account for valid changes in case mix, technology, and treatment patterns that legitimately affect hospital resource consumption. At the same time, we are also mindful of our obligation under section 1886(d)(4)(C)(iii) to make the DRG changes in a budget neutral manner. In light of this provision, we do not intend to recommend DRG modifications with inflationary outcomes that we are unable to predict and that may, therefore, result in a violation of the mandate of budget neutrality. Our goal is to refine our methodology so that we

can fulfill both statutory requirements in the most appropriate manner.

Comment: We received one recommendation that we seek a legislative change that would allow the DRG reclassification and recalibration budget neutrality adjustment to be based on estimated rather than actual experience. Thus, budget neutrality would require that, for the distribution of cases used for reclassification and recalibration of the DRGs, estimated total payments under section 1886(d) of the Act after reclassification and recalibration are equal to estimated total payments before reclassification and recalibration.

Response: The use of "estimated" versus "actual" payments is an issue only to the extent that we are unable to predict accurately the impact of modifications on program payments. Changing the law to require only that the estimated impact of DRG reclassification and recalibration be budget neutral does not address the inflationary effects of coding improvements and other areas prone to misestimation. Regardless of whether the statute requires that "estimated" or "actual" payments be budget neutral, we need to improve our methodology for projecting changes that will occur between the estimation year and the payment year in the distribution of cases, enabling us to fulfill both the letter and the spirit of the law. To the extent we are unable to improve the estimation methodology, we need to establish a methodology that will avoid building the inflationary impact of the changes into future program payments. Unlike other estimates that are redone on an annual basis (for example, estimated outlier payments), misestimating the effect of DRG changes results in a permanent increase in the average case weight. Thus, since implementation of the prospective payment system, the average case weight has increased 35 percent. Although some portion of this increase reflects real changes in the mix of cases treated by hospitals, we believe much of it is a result of improved coding practice. Thus, we will continue to seek suggestions and explore and evaluate a variety of methodologies to improve our ability to make our DRG modifications budget neutral.

Comment: Commenters argued that in analyzing the unanticipated change in case movement following the FY 1991 DRG changes, we overstated the impact of the changes on coding. These commenters believe that there is an actual increase in case complexity every year and that attributing all the change to improved coding practice overstates

the problem. The example used most frequently by the commenters is the HIV Infection DRGs. They believe that the incidence of these cases is increasing at such a rate that it could easily have accounted for the 123 percent increase we saw between FYs 1989 and 1991 data.

Response: We agree with the commenters that HIV infection is a condition for which there is real change in case numbers. And, in fact, we acknowledged this trend in the proposed rule (57 FR 23628). However, the increase in case numbers between those 2 years for HIV patients far exceeded the increase we would have expected based on the trends in previous years. We note that our methodology for determining the effect of the DRG changes compares the average DRG weight for the actual FY 1991 cases using the FY 1991 GROUPE and relative weights to the average DRG weight for the same cases using the FY 1990 GROUPE and relative weights. By using the actual FY 1991 cases on both sides of the comparison, all coding changes, whether real or not, are recognized. The analysis is designed to determine how much of the increase in the case-mix index is attributable to the DRG changes and recalibration. The analysis is not designed to determine how much of the observed case-mix change is real and how much is attributable to coding improvements.

Comment: Some commenters objected to our proposal to maintain the average case weight at 1.0 after recalibration. Many commenters urged us never to adopt this procedure. Other commenters agreed that normalizing the recalibrated DRG weights to an average of 1.0 each year and making an accompanying adjustment for real case-mix change in the annual update factor is appropriate, but they do not believe we currently have a method to distinguish real case-mix change from changes in coding practice.

Many of the comments expressed concern that, in an effort to control for changes in coding behavior, we would risk eliminating the effects of real case-mix increase. The commenters state that real case-mix changes are occurring due to shifts from inpatient to outpatient settings for less resource-intensive patients, increasing patient age, and improvements in technology. They believe that recalibrating to 1.0 would introduce a bias against recognizing new medical technologies and practices in DRG classification, particularly those that increase hospital costs.

Among the other recommendations received were suggestions that there

should be a built-in mechanism to reduce standardized amounts in future years to account for any overpayment in past years made as a result of DRG changes. It was suggested that HCFA develop and propose a method for measuring and reflecting real case-mix change in the update factor. This method should measure increases in case complexity within DRGs as well as across DRGs. However, one commenter was concerned that any positive real case-mix allowance HCFA recommended for the update factor would be vulnerable because section 1886(b)(3)(B)(i) of the Act specifies all future update factors applied to the standardized amounts. Legislation would be needed to ensure that the update factor in the law allows an explicit adjustment for real case-mix change.

ProPAC states that the proposal to rebase the case-mix index annually is consistent with the approach ProPAC recommended in its annual discussion of the prospective payment update factor through 1988, but indicated that it could not support such a methodological change unless the update were adjusted to reflect real case-mix change.

Response: As noted above, we will continue to work toward a methodology that will allow us to make the appropriate changes to the DRG classifications without risking an inflationary effect on payments. As a part of this process, we will carefully consider the concerns expressed by the commenters. We recognize that if we were to recalibrate to 1.0 each year, there would need to be an on-going adjustment to the standardized amounts to account for real case-mix change. In our update framework, we reduce the standardized amount for observed case-mix change and increase it for real case-mix change. Our estimate of real case-mix change is based on a study by the Rand Corporation using reabstracted medical records. We would need a mechanism to update the results from that study or an alternative way to determine real case-mix change.

Comment: The suggestion we received most frequently from commenters concerning better methods for estimating coding changes before we make DRG classification changes was that HCFA should conduct a detailed review of individual medical records every year. This review would ensure a more accurate estimate of case weights and would reduce the potential for eliminating changes in real case-mix growth.

Review of patient records from a prior period would provide empirical evidence to determine the extent to

which certain diagnoses and procedures are, in fact, present in the Medicare patient records but were not coded either because of lack of space on the bill or because they did not affect DRG assignment. This approach would help ensure that the new DRG weights would be correctly estimated before the reclassified DRGs are implemented and any resulting increase in case mix could be assumed to be attributable to legitimate changes in the types of cases treated by hospitals.

Response: Although the commenters have identified a mechanism to estimate the potential for coding improvement, we are uncertain that a review of patient records as a part of our analysis prior to making DRG classification changes is feasible. The process of collecting and reabstracting from actual medical records is a time-consuming process. We believe that using this method would delay any potential DRG changes while the reabstraction is taking place. It may be more appropriate as a method to determine retroactively how much of observed case-mix increase is attributable to real case-mix increase. This approach was taken by RAND Corporation in its research for HCFA under cooperative agreement 18-C-98489/9-01 to examine changes in case mix between 1981 and 1984. ("The Medicare Case-Mix Index Increase: Medical Practice Changes, Aging, and DRG Creep;" Grace M. Carter, Paul Ginsberg; June 1985.) In either event, reabstracting medical records would improve our ability to predict changes only to the extent that the information is already in the medical record and simply not reported on the bill. It would not help measure the coding changes that will result from improvements in recording information in the medical record in response to our DRG changes.

Comment: The commenters believe that, in the interest of fairness and equity, HCFA should publish the specifications for any new methodology for improved forecasting of coding changes due to reclassified DRGs in a notice of proposed rulemaking so that the hospital community has the opportunity to comment upon its potential effectiveness and feasibility.

Response: As has always been our practice in the past concerning the prospective payment system, we will publish any changes we make in proposed rule format for public comment.

Comment: One commenter asserted that a 1 percent increase in the average case weight does not necessarily translate into a 1 percent increase in Medicare inpatient hospital payments. If a higher proportion of cases classify to

relatively higher-weighted DRGs than had previously been the case, and these cases do not generate the same proportion of additional dollars in outlier payments as they do in basic DRG payments, then the aggregate prospective payment system expenditures will rise more slowly than the increase in the average case weight.

Response: We agree with the commenter that the effect of DRG changes in a given year on total program payments should take into account the effect on outlier payments in that year. As discussed below in section V.A of this preamble, we believe that the DRG changes that we made in FY 1991 were largely responsible for the outlier underpayment in that year and the estimated outlier underpayment for FY 1992. However, it is important to note that under our current recalibration methodology, the DRG changes have only a 2-year effect on outlier payments and a permanent effect on total program payments. Outlier payments are re-estimated each year, so that once the effect of the DRG changes is reflected in the MEDPAR file used to estimate outlier payments, any outlier underpayment resulting from those changes ceases. In contrast, the effect of the DRG changes on the case-mix index translates into a permanent increase in total program payments since the increase in the average case weight is built into the DRG relative weights through the normalization process. If we were to recalibrate to an average case weight of 1.0 each year, the DRG changes would have only a 2-year effect on both outlier payments and total payments.

III. Changes to the Hospital Wage Index

A. Background

Sections 1886(d)(2)(H) and 1886(d)(3)(E) of the Act require that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals. To fulfill this requirement, we construct an index that reflects average hospital wages in each urban and rural area relative to the national average hospital wage.

For determining prospective payments to hospitals in FY 1992, the wage index is based on a HCFA survey of hospital wage and salary data for all hospitals subject to the prospective payment system with cost reporting periods ending in calendar year 1988. Home office costs and fringe benefits associated with hospital and home

office salaries were included in the updated wage index. Contract labor and nonhospital direct wage costs were excluded from the wage index. The FY 1992 wage index reflected all corrections that had been made in the wage survey data through August 15, 1991.

Section 1886(d)(3)(E) of the Act requires that the hospital wage index be updated annually beginning October 1, 1993.

B. Wage Data Used in Determining the Hospital Wage Index for FY 1993

For discharges occurring on or after October 1, 1992, the wage index continues to be based solely on 1988 wage data. In determining the wage index for FY 1993, we incorporated all corrections of errors in the survey wage data that have been processed through August 15, 1992 since the construction of the wage index implemented for FY 1992. The final revised national average hourly wage is \$13.9937 compared to \$13.9752 used to establish the wage index values that were effective for discharges occurring on or after October 1, 1991.

The wage indexes for FY 1993 are shown in Tables 4a through 4c in the addendum to this final rule.

C. Revisions to the Wage Index Based On Hospital Reclassifications

Under section 1886(d)(8)(B) of the Act, for discharges occurring on or after October 1, 1988, hospitals in certain rural counties adjacent to one or more Metropolitan Statistical Areas (MSAs) are considered to be located in one of the adjacent MSAs if certain standards are met.

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRCB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The first hospital reclassifications based on the decisions of the MGCRCB took effect on October 1, 1991.

In determining the wage index values, the wage data for hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act is combined with the wage data for hospitals that were reclassified to the same MSA as a result of the MGCRCB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the MSA to which they have been redesignated. Therefore, the wage index

values were determined by considering the following:

- If including the wage data for the redesignated hospitals reduces the MSA wage index value by 1 percentage point or less, the MSA wage index value applies to the redesignated hospitals deemed to be a part of that MSA. The MSA wage index value is determined exclusive of the wage data for the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the hospitals that are redesignated are subject to the wage index value of the area that results from including the wage data of the redesignated hospitals. However, the wage index value for the redesignated hospitals cannot be reduced below the wage index value for the rural areas of the State in which the hospitals are located.
- Rural areas whose wage index values would be reduced by excluding the data for hospitals that have been redesignated to another area continue to have their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index values increased as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index calculated exclusive of the redesignated hospitals.

• The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, the wage index for an urban area may not be reduced, as a result of geographic reclassification, below the Statewide rural average.

We note that, except for those rural areas where redesignations would reduce the rural wage index value, the wage index value for each area is computed exclusive of the data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, there are a few MSAs listed in Table 4a that have no hospitals remaining in the MSA. This is because the hospitals in the original MSA have been reclassified to another area by the MGCRCB, and our records indicate that there are no other hospitals currently classified in those areas. For those areas, we have listed the Statewide rural wage index value.

The revised wage index values effective for discharges occurring on or after October 1, 1992 are shown in Tables 4a, 4b, and 4c of the addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. It should be

noted that for some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one area are included in the group of redesignated hospitals, and one or more hospitals (usually a rural hospital), receive the Statewide rural wage index value rather than the wage index value otherwise applicable to the redesignated hospitals.

The FY 1993 wage index values incorporate all geographic reclassification decisions that will be effective for FY 1993. The wage index values published in this final rule are different from those proposed in the June 4, 1992 proposed rule as a result of changes in the decisions made by the MGCRCB since the publication of the proposed rule that resulted from hospital appeals, discretionary review by the Administrator, withdrawals of reclassification requests, and wage index corrections. The reclassification changes affected not only the wage index values for specific geographic areas, but also whether redesignated hospitals receive the wage index value of the area to which they are redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index values for the areas from which the hospitals were redesignated were also affected. A hospital that requested to withdraw its application may not request that the MGCRCB decision be reinstated after publication of the prospective payment rates in this final rule.

Comment: Some commenters pointed out that the wage index for urban hospitals remaining in their original wage area is calculated exclusive of the wage data of those hospitals reclassified out of the area and that while most urban areas are protected from having their area wage index fall below the Statewide rural floor, urban areas with wage index values already below the Statewide rural wage index prior to any reclassification are not protected from a further decline in their wage index values. Similarly, in two states, New Jersey and Rhode Island, where there is no Statewide rural wage index, hospitals in these urban areas are also not protected. It was suggested that we provide "hold harmless" protection to urban areas that would preclude their wage index value from falling below their original (prior to any reclassification) wage index. One commenter indicated that our interpretation of the "floor" provision for FY 1993, as reflected in Table 4c, appears to give only reclassified rural

hospitals the benefit of the rural wage index floor. The commenter stated that this interpretation is contrary to the statute, which requires that the floor provision applies to any county whose wage index value falls below the Statewide rural value.

Response: Our rationale for not establishing a new "hold harmless" provision for urban areas whose wage index values are below the statewide rural wage index prior to reclassification and decline as a result of reclassifications is discussed thoroughly in the August 30, 1991 final rule (56 FR 43221). Section 1886(d)(8)(C)(iii) of the Act specifically precludes the reclassification of hospitals under sections 1886(d)(8)(B) and 1886(d)(10) of the Act from resulting in "the reduction of a county's wage index to a level below the wage index for rural areas in the State in which the county is located." The statute establishes a floor that applies only when a hospital's wage index value falls from above the Statewide rural wage index value to below the Statewide rural wage index value.

The statutory requirement of budget neutrality specifically applies only to reclassifications and wage index recomputations that occur as prescribed under statute. The statute is very specific with respect to the treatment of the wage index values for geographic areas from which and to which hospitals have been reclassified. We do not believe it is appropriate to establish a new "hold harmless" rule that would result in a significant change in the scheme constructed by Congress. Therefore, even if the change is warranted, we believe that it should be made through legislation.

With respect to our application of the provisions of section 1886(d)(8)(C)(iii) as reflected in Table 4c, we note that the rural floor applies not only to rural hospitals that were reclassified to an area where the wage index is less than the Statewide rural wage index for the area it came from, but also to urban hospitals whose wage index prior to reclassification is above the Statewide rural wage index value, and after being reclassified falls below the Statewide rural wage index value. The results for any area subject to this floor are incorporated in Table 4c. We note that for FY 1993, there are no urban areas for which the Statewide rural floor applies.

Comment: Two commenters asked that we use "real wage indexes" rather than the wage index calculated after the hospitals have been removed from the MSA as a result of reclassification. We received one comment suggesting that instead of our current practice of

inserting the Statewide rural wage index for MSAs that become "empty" as a result of reclassification, it would be more appropriate to use the wage index that the MSA had prior to any reclassifications. In this way, hospitals would be better able to judge whether to withdraw their application for reclassification. The commenter also stated that it would be helpful if we indicated how many hospitals are used to calculate the wage index for each MSA and which MSAs are "empty" because all hospitals were reclassified out of the MSA.

Response: The law is very specific concerning how the wage index values should be calculated as a result of hospital reclassifications. Congress clearly contemplated that reclassified hospitals would not be considered part of their original labor market areas for purposes of computing the wage indexes for those areas. This is evidenced by section 1886(d)(8)(C) of the Act, which provides an exception to this requirement for those rural areas where reclassification of hospitals from those areas would reduce the rural wage index value. Accordingly, we believe the statute is clear that the wage index for each area would be computed exclusive of the data for the hospitals that have been granted reclassification from those areas.

Regarding the use of Statewide rural wage index values for MSAs that no longer have any hospitals as a result of reclassifications, we believe this comment has some merit in that hospitals would have difficulty determining whether to withdraw their applications in cases where the MSA is "empty." Therefore, in future proposed rules, where all the hospitals are tentatively reclassified out of the MSA, we will provide information on the wage index value for that area prior to any reclassifications. We will also indicate which areas no longer contain any hospitals. However, we will continue to assign the Statewide rural wage index value to the "empty" MSA. These values are needed in the event a new hospital or any other hospital that is not represented in the 1988 wage survey data furnishes services to Medicare beneficiaries during the fiscal year. In an empty MSA, all the hospitals that reported wages in 1988 are reclassified, so no hospitals currently exist for wage index purposes. We believe that any new hospital in the MSA should receive the Statewide rural wage index until such time that the new hospital's data is utilized in the calculation of an updated wage index. Since there is no rural Statewide average for New Jersey or Rhode Island, we will assign the wage

index value before reclassification to any "empty" MSA in those States.

We see no purpose in publishing the number of hospitals used in calculating each MSA's wage index value. Since the average for each area is hour-weighted, rather than hospital-weighted, each hospital's influence on the area wage index is dependent on the number of hours of employment incurred by that hospital. For purposes of this final rule, the Statewide rural wage index was used for the following MSAs where all hospitals were reclassified from the MSA: Bloomington, IN; Bradenton, FL; Bremerton, WA; Cedar Rapids, IA; Danville, VA; Elkhart-Goshen, IN; Jacksonville, NC; Janesville-Beloit, WI; Lawrence, KS; Lewiston-Auburn, ME; Melbourne-Titusville, FL; New Bedford-Falls River-Attleboro, MA; Niagara Falls, NY; Pine Bluff, AR; Tacoma, WA; Trenton, NJ (pre-reclassification value); York, PA; Yuba City, CA.

D. Midyear Corrections to the Wage Index Values

It has been our policy under § 412.63(p)(2) to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis. However, implementation of midyear corrections has resulted in several problems related to the reclassification of hospitals by the MGRB.

In the June 4, 1991 final rule with comment period concerning the MGRB (56 FR 25477), we indicated that the MGRB would use the latest updated survey data, including midyear corrections, to assess reclassification requests. We adopted this policy in order to ensure that hospitals whose applications were submitted based on corrected wage data would be treated fairly. However, because wage data corrections are processed on an ongoing basis throughout the year, the outcome of a hospital's reclassification request may in some cases depend on whether the intermediary's audit and our subsequent processing of its wage correction are completed before the MGRB issues its decision on the hospital's application. That is, since the MGRB makes its determination based on the data available at the time a hospital's case is being considered, whether a hospital meets the criteria for reclassification for purposes of the wage index may depend on the timing of the implementation of a wage correction.

Also, under section 1886(d)(8)(C) of the Act, the wage index applicable to reclassified hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on

the wage index value for the MSA to which they have been redesignated. As explained above, if the impact is a reduction of 1 percentage point or less, the reclassified hospitals receive the MSA wage index value. If the impact is a reduction of greater than 1 percentage point, the reclassified hospitals receive the wage index value that results from combining their wage data with the MSA data. This combined value is normally lower than the MSA value. Under our current policy, we have had instances in which a correction to the wage data for a hospital in an MSA has increased the impact of reclassifications on the MSA wage index value to greater than 1 percentage point. In these situations, reclassified hospitals that had been receiving the MSA wage index value became subject to the lower combined wage index value. Thus, solely as a result of another hospital's wage corrections, payments to these reclassified hospitals were reduced midway through the fiscal year. These hospitals are confronted with an unanticipated reduction in revenues when their Medicare payments are reduced because of midyear wage data corrections.

The current wage index based on 1988 calendar year data has been in effect since FY 1991. Thus, we believe that hospitals have had sufficient time to review their wage data and submit corrections where appropriate. Therefore, in order to resolve the problems described above, we proposed eliminating midyear wage data corrections effective with requests for correction received on or after October 1, 1992. As discussed below, after consideration of all comments received on this issue, we are implementing this provision as proposed.

Under this provision, only those requests for wage data corrections for 1988 calendar year data, that are submitted with supporting documentation and received by the fiscal intermediary no later than September 30, 1992 will be implemented as a midyear wage index change. Changes based on those corrections will be made on a prospective basis in FY 1993 in accordance with our current policy. The specific requirements are as follows:

- A hospital that wishes to make a correction to its reported 1988 calendar year wage data must submit to its fiscal intermediary a revised wage survey form (HCFA 2561) along with supporting documentation by no later than September 30, 1992.

- Within 30 days, the fiscal intermediary will review the data and adjust it as appropriate. Upon

completion of its review, the fiscal intermediary will forward the hospital's request to HCFA's Division of Hospital Payment Policy, along with a letter that summarizes the hospital's request and makes a recommendation concerning the appropriateness of the requested wage correction.

- HCFA will review the request and, if HCFA determines that a wage correction is warranted, the wage index value for the area in which the hospital is located will be revised on a prospective basis.

- In cases where the hospital submitted supporting documentation but additional information is required by the fiscal intermediary or HCFA, the hospital must submit the required information within 30 days of receiving the request.

As required by section 1886(d)(3)(E) of the Act, we will update the wage index data on an annual basis beginning October 1, 1993. We are currently collecting wage data on an ongoing basis as part of the Medicare cost report. Fiscal intermediaries are transmitting these wage data through the Hospital Cost Report Information System (HCRIS). We expect to use the latest data available through HCRIS to update the wage index on an annual basis. A hospital that wishes to make corrections to the wage data reported on its Medicare cost report will do so through its fiscal intermediary in accordance with the normal cost report revision or reopening procedures. Fiscal intermediaries will forward any corrections to HCFA through HCRIS, and we will incorporate those corrections into the wage index on an annual basis, at the same time we update the wage index for payment purposes.

Comment: Several commenters, including some of the major hospital associations, indicated that they believed the sunset provision for submitting midyear wage index corrections based on the 1988 wage survey data is reasonable. There were two commenters who indicated that hospitals should be able to continue to submit corrections and that we should not eliminate midyear corrections. In addition, one of these commenters indicated that we should make retroactive changes to the wage index if a correction results in a revision of 1 percent or more to the area wage index.

Response: A prudent hospital would have ensured that data submitted for the 1988 wage survey was complete and accurate. Since the survey was completed in 1990, we believe that hospitals have had sufficient opportunity to review the wage data,

and to submit corrections where appropriate. Moreover, because the wage index data will be updated annually, problems with any data errors will no longer be perpetuated from year to year. Therefore, effective October 1, 1992, fiscal intermediaries will no longer accept any requests for corrections to the 1988 wage survey data. In the near future, we will issue instructions to the intermediaries for reviewing, verifying and submitting completed requests to HCFA. It is our intention that all corrections to the 1988 data be completed on or before January 1, 1993, so that the latest, corrected wage data will be available to the MGRB when deliberating on geographic reclassification requests effective for FY 1994.

With respect to retroactive corrections to the wage data, it has been our longstanding policy to make any corrections to the wage index on a prospective basis only. Our policy for applying prospective corrections to the wage index was originally set forth in the preamble to the January 3, 1984 final rule (49 FR 258) implementing the prospective payment system and was later codified at § 412.63 as part of the September 4, 1990 final rule (55 FR 36042). Under the policy, if a correction of a data error changes the wage index value for an area, the revised wage index is effective prospectively from the date the data correction is approved. This policy was established so as not to disadvantage hospitals in areas where a wage data error was detected by waiting until the beginning of the next fiscal year to recognize the correction.

Congress has twice visited this issue and has failed to require that we make wage data corrections retroactively. In section 9103 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), Congress eliminated the provision of section 2316 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) that would have required retroactive application of the new HCFA wage index that was implemented May 1, 1986. Congress provided that the revised wage index be applied prospectively, which is consistent with the prospective only rule established in January 1984. Congress again addressed this issue in Pub. L. 101-239. In section 6003(h) (5) of Pub. L. 101-239, Congress did require the Secretary to make retroactive adjustments in the 1984 wage data to account for errors, but only under very limited circumstances. The fact that Congress severely limited the application of this provision, not only with respect to the specific database,

but also with respect to a specific situation using such database, indicates Congressional intent that the provision have no further applicability beyond the situations specified in the statute. We should also point out that when corrections were made in these very limited cases, the hospitals who committed the errors in reporting the original data did not receive any benefit of the retroactive wage index corrections.

Comment: We received a number of comments concerning perceived problems with the wage data currently being collected through the Medicare cost report that will be used to formulate future wage index updates. Specifically, the commenters stated that the instructions for fringe benefit and contracted services should be further defined and clarified. One commenter suggested that contracted labor be expanded to include all contracted services rather than only those directly related to patient care. Also, each commenter on this issue expressed concern that the current survey instrument (the worksheet S-3, Part II of the HCFA-2552) does not allow hospitals to remove wages associated with non-hospital salaries that are included in the overhead of the other cost centers.

Response: These comments do not directly apply to the proposed wage index changes for FY 1993; rather, they address issues related to the calculation and formation of future wage indexes. We have already taken steps to revise the cost reporting instructions accompanying the worksheet S-3, Part II with respect to fringe benefits. This revision will be included in the latest cost report revisions (HCFA 2552-92), which will be effective for cost reporting periods beginning on or after October 1, 1991. The revised instructions will enable hospitals to more accurately determine appropriate fringe benefit costs to be reported for purposes of the wage index calculation.

Regarding the expansion of the contracted services definition to include all contracted services, we continue to believe it is not appropriate to include contract services other than those directly related to patient care for a number of reasons. First, many contracts, especially those that are not for direct patient care services, include items that are not merely labor costs. Frequently, these costs include supplies and equipment that may be provided by the contractor, and thus may not reflect current or local salary trends. Second, it is frequently difficult or impossible to ascertain the appropriate hours

associated with the provision of some types of contracted services. Hospitals have consistently indicated problems with accurately determining these hours, especially for services such as contracted housekeeping and laundry. Finally, it is the contracted services such as those associated with nursing and technicians' services that hospitals must incur due to shortages of workers in those skilled areas that have most disadvantaged hospitals by not including these services in the wage index calculation. Since these services are directly related to hands-on patient care, hospitals can more readily maintain accurate records on hours worked in this context than in the case of other contracted services. If we did not limit the nature of contracted services included in the wage data, it is likely that the reliability of the data would be questionable (as in the case of the 1988 survey data) because of problems with accurately reporting contracted labor. Therefore, we believe it is appropriate to limit contract services to those directly related to patient care.

Regarding the exclusion of overhead costs associated with non-hospital services, we are taking measures to allocate overhead salaries to the excluded areas of the hospital. For the FY 1994 wage index update, we will be asking fiscal intermediaries to obtain data with respect to hours worked in the overhead (general service) cost centers and will develop a methodology to allocate overhead salaries to non-hospital cost centers that are excluded from the wage index computation. We note that the revised cost report (HCFA 2552-92) will include an additional line to capture these data in the future.

Comment: One commenter suggested that since we had allowed hospitals in Nebraska to make changes to their current wage survey data to carve out overhead wage costs related to excluded areas such as SNFs, all hospitals should have the same opportunity to revise their wage data.

Response: The premise of the commenter's suggestion is incorrect. No changes were made to any 1988 hospital wage survey data to remove overhead salary costs associated with non-hospital services. We have had several conversations with representatives of Nebraska hospitals on this issue. However, these discussions were related to future updates to the wage data using data submitted on the Medicare cost report (HCFA-2552, worksheet S-3, Part II). Because the data necessary to allocate overhead salaries to the excluded wage areas are not

available for all hospitals, we do not believe it would be appropriate to allow individual hospitals to adjust their 1988 survey data to eliminate overhead salaries associated with those excluded areas.

Comment: One commenter indicated that it is very difficult to make corrections to the wage index data reported on the HCFA-2552, worksheet S-3, Part II since the data are transmitted electronically to HCFA using the Hospital Cost Report Information System (HCRIS). The commenter indicated that instructions are needed for fiscal intermediaries that would require them to transmit corrections to the wage survey data through HCRIS on a systematic basis. This would ensure that the most current and updated data are used to construct future wage indexes.

Response: We concur that it is important that fiscal intermediaries react timely to requests from hospitals to submit revisions to the HCFA-2552, worksheet S-3, Part II. Since we intend to update the wage index yearly based on the data reported through HCRIS, we will issue instructions to the fiscal intermediaries directing them to transmit all corrections to the wage form via HCRIS prior to our development of any revised wage index incorporating the cost report data.

Comment: We received one comment suggesting that we include contracted labor in the calculation of the current wage index.

Response: As we indicated in the final rule for FY 1992, the data submitted from hospitals for contracted services were incomplete and plagued with problems. As mentioned earlier, hospitals related numerous problems in determining what contracted services to include and in determining the hours associated with these services. A thorough discussion as to why contracted labor is not included in the current survey was included in the September 4, 1990 final rule (55 FR 36036).

E. Revised Metropolitan Statistical Area (MSA) Definitions Based on 1990 Census Data

In the August 30, 1991 final rule (56 FR 43202), we indicated that the Office of Management and Budget (OMB) expected to issue revised MSA definitions based on 1990 census data in June 1992. We had anticipated implementing the new MSA definitions in the FY 1993 final rule in accordance with our policy of adopting MSA changes at the beginning of the Federal fiscal year following OMB's

announcement (see § 412.63(b)(4)). However, we pointed out potential problems associated with implementing major MSA changes (such as reconfiguring the wage index and standardized amounts and determining appropriate geographic reclassifications) in a final rule without prior notification in the proposed rule. We also solicited public comments on possible approaches to implementing the revised MSA definitions.

Because of significant delays in obtaining the necessary data from the Bureau of Census, OMB was unable to publish the revised MSA definitions by June 30, 1992, as originally planned. The delay in publication of the new MSA definitions has precluded the implementation of the revised MSAs in this final rule. Therefore, we now plan to implement the revised MSA definitions based on 1990 census data in FY 1994. Since OMB's originally expected publication date was actually 1 year ahead of normal schedule (the MSAs based on 1980 census data were announced in 1983 and implemented in FY 1984), implementation of the revised MSAs in FY 1994 is on a comparable schedule to implementation of the 1980 census data. Therefore, we intend to announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

Comment: We received several comments indicating that even though OMB has not yet published the new MSA definitions based on the 1990 census data, we should recognize the new definitions. The commenters believe that the information concerning the revised MSA definitions is currently available and therefore should be used immediately because some hospitals may be adversely affected by the delay in implementation. In addition, we received comments asking that we provide an exception for hospitals in the Niagara Falls, NY and Buffalo, NY MSAs to allow those areas to combine into a single large MSA on the premise that OMB will recognize those areas as a single MSA once the new definitions are issued. Some commenters stated that it is inappropriate to use the current definitions for MSAs for submitting applications to the MGCRB when new MSA definitions will be in effect when the decisions become effective in FY 1994.

Response: OMB has not yet issued its revised MSA designations based on 1990 census data. Until OMB makes its announcement, definitions are subject to change and are not final. We are aware of potential changes that OMB is

considering, but we are required to use the current MSAs until the revised MSA definitions have been officially announced. We note that the Federal Executive Committee on Metropolitan Statistical Areas, which makes recommendations to OMB with respect to the MSA definitions, has not yet completed its deliberations, nor have any recommendations been made to OMB as of this date. It would be inappropriate to recognize some potential changes, while ignoring others, or to make changes based on preliminary information that is subject to change once OMB makes its final announcement. Therefore, as we indicated in the proposed rule, the delay in the publication of the new MSA definitions has precluded the implementation of revised MSAs in the final rule. We intend to announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

IV. Changes Concerning Reclassifications by the Medicare Geographic Classification Review Board

A. Background

Section 6003(h)(1) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239), enacted on December 19, 1989, added section 1886(d)(10) to the Act to provide for creation of the Medicare Geographic Classification Review Board (MGCRB). Guidelines concerning the criteria and conditions for hospital reclassification are located at 42 CFR part 412 subpart L, §§ 412.230 through 412.236. (Regulations concerning MGCRB composition and procedures are located at §§ 412.246 through 412.280.) The purpose of the criteria is to provide direction, to both the MGCRB and hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals for purposes of payment under the Medicare prospective payment system. Hospitals may be reclassified individually for purposes of their wage index or standardized amount or both. Hospitals may be reclassified as a group for purposes of both their wage index and standardized amount, but not solely for one of these measures.

A request for reclassification must be filed by October 1 of the Federal fiscal year preceding the Federal fiscal year for which the reclassification decision would be effective. For example, a request for reclassification effective for FY 1994 must be filed by October 1, 1992. The MGCRB is required to issue its

decision within 180 days of October 1. A reclassification decision by the MGCRB is generally effective for 1 year. However, depending on its assessment of the facts supporting an individual hospital's or group of hospitals' request for reclassification, the MGCRB may provide for an automatic 1 year renewal of its decision.

Section 1886(d)(8)(D) of the Act requires that the effect of decisions of the MGCRB be budget neutral. Under this section, the Secretary is to adjust the standardized amounts for urban hospitals to ensure that total aggregate payments under the prospective payment system after the incorporation of the geographic reclassifications under sections 1886(d)(8) (B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these reclassifications. Also, the standardized amounts for rural hospitals are to be adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increase nor decrease as a result of the reclassifications.

The first reclassification decisions issued by the MGCRB became effective on October 1, 1991 for discharges occurring in FY 1992. The August 30, 1991 final rule (56 FR 43196) setting forth the FY 1992 prospective payment system rules reflected 930 hospital reclassifications approved by the MGCRB and the HCFA Administrator effective for FY 1992. The effects of the MGCRB reclassification decisions on FY 1992 payments were significant. To meet the statutory budget neutrality requirements, each of the urban standardized amounts (large and other) was reduced 1.1 percent. Among all hospitals not reclassified, the overall impact of hospital reclassifications was an average decrease in payment per case of about 1 percent.

In the August 30, 1991 final rule (56 FR 43198), we also discussed public comments we had received concerning geographic reclassification issues raised in the June 3, 1991 proposed rule for the prospective payment system (56 FR 25178) and the June 4, 1991 final rule with comment period for the MGCRB (56 FR 25458). Many commenters addressed the impact of geographic reclassification on payment to hospitals. In response to the comments, we stated in the August 30, 1991, rule that we intended to evaluate the FY 1992 reclassifications made under the current guidelines and to propose such revisions as may be appropriate for future application cycles. In addition, we solicited public comments concerning those potential

revisions. We described the public comments we received in response to this request in the June 4, 1992 proposed rule (57 FR 23633).

B. Changes to the Regulations

Thus, as described above, the changes in the reclassification guidelines were formulated after multiple occasions for public comment. They were also based on our analysis of the FY 1992 reclassifications. We also took into account the effects of reclassifications, which, because they must be budget neutral, result in increased payments to one group of hospitals being offset by reduced payments to other groups. In light of this effect, we have an obligation to assure both that those hospitals meriting reclassification are afforded proper consideration and that other hospitals are protected from the effects of inappropriate reclassifications. In addition, we determined that a number of issues which have arisen concerning the reclassification guidelines warranted clarification.

Accordingly, as discussed in detail below, we proposed in our June 4, 1992 proposed rule to make several changes to the MGCRB guidelines. After considering all comments received in responses to the proposed rule, we are implementing the following changes to the MGCRB guidelines in this final rule. The changes will not affect reclassifications that will be effective for discharges occurring in FY 1993. However, given the 1-year time lag between the effective date of any changes to the MGCRB regulations and the effect of these changes on hospital reclassifications, we believe it is essential that the following changes be implemented in time to affect applications that will be processed by the MGCRB during FY 1993. Therefore, the new guidelines will be effective for applications submitted by October 1, 1992, for geographic reclassifications effective for discharges in FY 1994.

1. General Guidelines—Reclassifications for Individual Hospitals

a. *Reclassification to a Single Geographic Area* (§ 412.230(a)(1)). We are revising § 412.230(a)(1) to specify that a hospital may seek reclassification to only one area. In situations where a hospital can qualify for the wage index of one area and the standardized amount of another area, the hospital must decide the area to which it wishes to be reclassified and must indicate that decision in its application.

Comment: One commenter stated that hospitals should not be limited to applying to only one area for both the wage index and the standardized

amount. The commenter asserted that because the pattern of hospital expenditures for wages and salaries may be different from the pattern of expenditures for utilities and supplies, it would be appropriate for a hospital to reclassify to one area due to the comparability of labor costs and another area for its nonlabor costs.

Response: The standardized payment amount a hospital receives includes both labor and nonlabor payments. Moreover, more than 71 percent of the hospital's operating costs covered by the standardized amount are labor-related costs. Since payments for labor are reflected in both measures, we do not believe it is appropriate for a hospital to be reclassified to one area for its wage index and a different area for its standardized amount.

In addition, the purpose of the MGCRB process is to permit hospitals that are disadvantaged by their geographic classification to obtain a more appropriate classification to the area with which they have the most economic interaction. Therefore, we believe that hospitals that meet the general proximity criteria should be reclassified to only one alternative geographic area. For the same reasons, we believe it also is appropriate to provide that sole community hospitals and rural referral centers may be reclassified to only one area using either the special access rule or the proximity rule, but not both.

b. *Individual Urban Hospital Reclassification to a Rural Area* (§ 412.230(a)). We are revising § 412.230(a)(1) to clarify that the only types of reclassifications that are permissible are rural to urban, urban to urban, and rural to rural reclassifications.

Comment: One commenter did not agree that urban to rural reclassifications should be disallowed. The commenter argued that a small MSA containing one hospital surrounded by rural counties is an example of a situation where an urban hospital would compete with rural hospitals.

Response: Section 1886(d)(8)(C)(i) of the Act, which addresses application of the wage index to reclassified hospitals, specifically references reclassifications of rural hospitals to urban areas and of urban hospitals to other urban areas. However, the statute does not require HCFA to provide for reclassification of urban hospitals to rural areas.

Moreover, we disagree that the situation described by the commenter demonstrates that a hospital should be allowed to reclassify from an urban area to a rural area. We believe the situation

of hospitals located in small MSAs surrounded by rural areas is very different from a rural hospital near the border of another state. A lone hospital in an MSA already receives a wage index that is fully reflective of its own wage costs. As such, the hospital is not being unfairly disadvantaged by its wage index.

We recognize that an urban hospital in an MSA surrounded by rural areas may compete with a few rural hospitals in its vicinity. However, the rural labor market area is comprised of all rural hospitals in the State, and would be less representative of the hospital's labor market than an area comprised of hospitals in the same geographic vicinity. In fact, the most common criticism of the rural wage index is that it is an average of all the rural hospitals in a State and may not be representative of the wage costs in different regions of the State. It would be inappropriate to reclassify a hospital from a labor market area based on the data for geographically proximate hospitals to one based on hospitals dispersed throughout the State. This is in contrast to a rural to rural reclassification, which involves reclassification from one broad labor market to another. In that case, a rural hospital near the border of an adjacent State could be more like the hospitals in the next State than in its own State. It is for these reasons that, while not required by the statute, we decided to provide for rural to rural reclassifications and not to provide for urban to rural reclassifications.

c. *Special Access Rule for Rural Referral Centers and Sole Community Hospitals Seeking Reclassification* (§ 412.230(a)(4)). Consistent with the change we are making to § 412.230(a)(1), we are revising the regulations to specify that a sole community hospital or rural referral center may not be redesignated under both the special access rule and the general proximity criteria in order to reclassify to different areas for wage index and standardized amount purposes.

Comment: One commenter pointed out that under § 412.230(a)(4)(iii), HCFA neglected to recognize that a hospital designated as either a rural referral center or a sole community hospital or both would be allowed to reclassify to the nearest urban area or the nearest rural area.

Response: We have amended the regulations text to reflect the fact that these hospitals may reclassify to the nearest urban area or, if the hospital is closer to another rural area than an urban area, it has the option of requesting reclassification to that rural

area rather than the nearest urban area. Consistent with the guideline that allows rural hospitals to reclassify to another rural area, we believe the same type of reclassification should also be afforded to sole community hospitals and rural referral centers that apply for reclassification under the special access rule. The MGCRB has currently been allowing such reclassifications. However, consistent with the current requirement under the special access rule that the hospital must be reclassified to the nearest urban area, we believe such reclassifications should be allowed only in those situations where the hospital is closer to another rural area than an urban area. In that situation, the hospital would have the option of seeking reclassification to the nearest rural area, or to the nearest urban area.

Comment: One commenter pointed out that some hospitals may be in jeopardy of losing their rural referral center status as a result of triennial reviews that will begin October 1, 1992, if the existing "grandfather" provision for such status is not extended by legislation. Thus, hospitals that previously were able to qualify for reclassification based on the special access rules under § 412.230(a)(4) would no longer be able to do so. However, because of the uncertainty as to whether the grandfather provision will be extended, hospitals that would lose their status, absent grandfathering, may have to apply for reclassification under both the special access rule and the proximity rule. This commenter stated that the MGCRB should determine whether a hospital can qualify under the special access rule based on its status as of the date of the MGCRB's review.

Response: We agree with the commenter and are revising § 412.230(a)(4) to specify that any hospital that qualifies as a rural referral center or sole community hospital as of the date of the MGCRB's review of its application is eligible to request reclassification under the special access rule. This is consistent with current MGCRB policy that the wage data to be considered is the data available at the time of the MGCRB's review. We will provide the MGCRB on an ongoing basis with information on changes in hospital status. Hospitals should anticipate any change in their rural referral center status as a result of triennial reviews and apply for reclassification accordingly. A hospital that is uncertain whether its RRC status will be in effect as of the date of the MGCRB's decision may wish to apply under both the special access and, if it is eligible,

proximity guidelines. At the time the MGCRB makes its decision, the hospital's reclassification request will be reviewed under the special access rule, if the hospital has retained its rural referral center status, or the proximity requirements, if the hospital has lost its rural referral center status. We note that any Administrator review of an MGCRB decision in such a case will be based on the hospital's status at the time of the MGCRB's decision.

d. Guidelines for a Hospital Requesting Reclassification for Wage Index Purposes (§ 412.230(e)). As proposed in our June 4, 1992 proposed rule, we are revising the wage index guidelines at § 412.230(e) to add the requirement that a hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located. The 108 percent threshold is based on the national average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (12 percent). Currently, the 85 percent standard for the relationship between the hospital's wages and the average hourly wage of the area to which it requests reclassification (found in § 412.230(a)) approximates the average hospital wage as a percentage of its area wage less one standard deviation. (To be consistent, this provision also replaces the 85 percent standard with an 84 percent standard (96 percent minus one standard deviation)). Thus, to qualify for a wage index reclassification, a hospital must have an average hourly wage that is more than one national standard deviation above its original labor market area and not less than one national standard deviation below its new labor market area. We are adopting this change as an additional standard for wage index reclassifications. Thus, the revised wage index guidelines at § 412.230(e) will now specify that a hospital can be reclassified only if its average hourly wage is at least 108 percent of the average hourly wage of hospitals in its original labor market area and at least 84 percent of the average hourly wage of the hospitals in the area to which it is seeking reclassification (or 90 percent of the average hourly wage after adjustment for occupational mix).

We have included in section V of the addendum to this final rule new Tables 4d and 4e, which list the inflated average hourly wage for each labor market area before any geographic reclassifications. These tables can be used to make the average hourly wage comparisons for purposes of filing a

wage index reclassification request. We note that the average hourly wages are subject to change once the final corrections to the 1988 wage data have been processed (see wage index discussion in section III of this document) and that the MGCRB will rely on the latest corrected wage data available at the time of its decision. As we indicated in the proposed rule, the hospital-specific data supplied to hospitals by HCFA during the application process already reflect the average hourly wage for the hospital's own labor market area. In addition, we are publishing the average hourly wage for each labor market area in Tables 4d and 4e. Therefore, we do not believe it is necessary to provide by rule an automatic extension for perfecting applications for FY 1994 reclassifications. However, we note that under § 412.256(c)(2), the MGCRB may, for good cause, grant a hospital that has submitted an application by October 1, an extension beyond October 1 to complete its application.

We received over 350 comments on the proposed change to the guidelines on reclassification for purposes of the wage index. These comments and our responses are presented below.

Comment: In general, hospitals located in large urban areas that have not benefited from geographic reclassification expressed strong support for the revised guideline that requires that, to be reclassified, a hospital's average hourly wage must be at least 108 percent of the average hourly wage of hospitals in the geographic area in which the hospital is located. They believe that the intent of the original legislation was to adjust payment levels in those special cases where a national payment rule could not appropriately address local circumstances. They stated that the original guidelines were too liberal to ensure that all qualifying hospitals were truly disadvantaged by their current geographic classification. As a result, the guidelines had an overly adverse impact on urban hospitals through the required reduction in the urban standardized amount to offset the cost of increased payments to reclassified hospitals. In addition, ProPAC supported the change stating that the "Commission believes the Secretary's solution strikes a reasonable balance between the need to provide relief to hospitals disadvantaged by their current geographic classification and the need to avoid inappropriate reclassifications."

In contrast, most of the commenters who strongly opposed the new

guidelines represent hospitals that are currently reclassified for purposes of the wage index. They believe that the 108 percent guideline is contrary to Congressional intent. Specifically, these commenters believe that neither the statutory requirements under section 1886(d)(10)(D) of the Act nor any other legislative directive indicates that Congress intended to limit the number of reclassified hospitals or contemplated the comparison of a hospital's wages to the average hourly wages in the area in which it is located. The commenters stated that the proposed guideline added a new factor to those that Congress intended that we consider. They expressed the opinion that the new guideline also reflected a change in focus from the previous MGCRB regulations, citing a recent court decision's affirmation of the proximity requirements based, in part, on the court's assessment that those requirements were consistent with the goal of the reclassification process "to adequately compensate hospitals that face increased costs due to competition with hospitals in geographic areas reimbursed at higher rates under the Medicare system." *Universal Health Services of McAllen, Inc. v. Sullivan*, 770 F. Supp. 704, 714 (D.D.C. 1991). The commenters believe the new threshold is an unreasonable obstacle to achieving this goal. Finally, many commenters expressed their belief that the new guideline was "arbitrary" and "outcome-oriented," that is, that HCFA selected the 108 percent threshold merely to achieve a satisfactory number of reclassifications. One commenter stated that this is evidenced by our failure to provide a similar guideline for the standardized amount since such a guideline would not affect as many hospitals.

Response: It is important to note from the outset that the Secretary's obligations under the prospective payment system extend beyond the implementation of section 1886(d)(10) of the Act. Specifically, under section 1886(d)(8)(D) of the Act, the Secretary is required to make a proportional adjustment in the standardized amounts for hospitals located in an urban area to assure that the provisions of sections 1886(d)(8) (B) and (C) or decisions issued pursuant to the MGCRB guidelines do not result in aggregate payments under the prospective payment system that are greater or less than those that would otherwise be made. The Secretary's obligation to effectuate this provision, commonly referred to as the "budget neutrality" provision, in a responsible manner is no

less important than his duty to publish reclassification guidelines which are consistent with the purpose of section 1886(d)(10). In other words, the Secretary is equally responsible for assuring that hospitals meriting reclassification are afforded proper consideration and for protecting other hospitals against any effects of the budget neutrality adjustment which may result from inappropriate reclassifications. In recognition of both duties, the Secretary has repeatedly solicited public comment on the reclassification guidelines and has examined the results of reclassification to ensure that his guidelines are accomplishing their intended purpose. We believe that the inclusion of the 108 percent threshold in the guidelines fulfills this dual responsibility. It provides a reasonable standard for measuring one of the factors which should be considered to achieve appropriate reclassifications, i.e., how a hospital's own wage level compares to the wage level reflected in the wage index value for its current area.

Some commenters stated that the implementation of the new wage index guideline is contrary to the authority given the Secretary under the statute or contrary to legislative intent. We disagree. The Secretary has been given broad authority under the statute to determine the factors which should be considered in adjudicating applications for reclassification under section 1886(d)(10) of the Act. Section 1886(d)(10)(D)(i) provides that:

The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by Medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

A guideline that compares a hospital's wages to the wage level in its own area does not create a standard inconsistent with any of the four factors the Secretary has been directed to include in his guidelines. Moreover, a plain reading of the statute reveals that Congress did not intend to limit the

guidelines to the four factors listed in section 1886(d)(10)(D)(i). In fact, the use of the word "include" indicates Congress' grant of authority to issue guidelines in addition to those expressly mentioned by the Act. In addition, nothing in that section or other relevant portions of the Act restricts the Secretary's authority to amend his initial guidelines for future application periods in consideration of additional factors.

There is nothing in the legislative history that indicates either that Congress intended the guidelines to be static or that suggests that promulgation of the 108 percent guideline is contrary to Congressional intent. In fact, the commenters have not pointed to any portion of the legislative history of section 6003(h)(1) of Public Law 101-239, the original legislation that created the MGCRB process, that contradicts the Secretary's authority to promulgate a threshold that compares the hospital's wage level to that of the area where it is located.

Moreover, although it included a number of revisions to section 1886(d)(10) of the Act, section 4002(h) of Public Law 101-508 did not change any of the reclassification criteria which the Secretary had published in September 6, 1990 interim final rule. We agree that this indicated that Congress generally endorsed the approach that the Secretary had outlined in his September 6, 1990 guidelines. However, section 4002(h) did not restrict the Secretary's authority to consider other factors or to further refine the reclassification guidelines at a later date.

However, some commenters have pointed to certain language in the Conference Committee report accompanying Public Law 101-508 to support their contention that we are adding a factor which Congress did not intend for us to consider. Specifically, they assert that the fact that Congress recommended a lower criterion for reclassification for purposes of the wage index is evidence that Congress would not now support this new guideline. We do not believe that the legislative history supports this contention.

The Conference Report which accompanied Public Law 101-508 reflects Congress' acknowledgement that the Secretary has the ultimate authority, absent explicit Congressional direction to the contrary, to assess the completeness and effectiveness of his guidelines and to make appropriate changes for future application periods. This conclusion is reflected in the manner in which Congress identified two areas of the original guidelines which it believed that the Secretary

should reconsider, i.e., group applications and the numeric threshold for the wage index guideline. With respect to group applications, the conferees stated that they believed that the omission in the September 6, 1990 interim final rule, of guidelines for urban hospitals to seek reclassification as a group was contrary to the intent of Congress and "should be rectified at the earliest possible date."

In the second area, concerning numeric guidelines, the report concluded:

The conferees are also concerned that the thresholds for consideration of applications by the board may be set too high and would urge the Secretary to consider changing them. In particular, the Committee is concerned that the 85 percent criterion for average hourly wages is too high and that the Secretary should consider a threshold of 70 percent for this purpose."

(H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990))

It is axiomatic that Congress could have enacted both suggested changes by adding them to the legislation. Instead, it left any necessary rectification of the problems identified and the timing of the changes to the Secretary. Moreover, it left the ultimate evaluation of the appropriateness of the 85 percent threshold to the Secretary. Accordingly, we believe that the report establishes that Congress itself is aware that it has given broad authority to the Secretary to determine which guidelines are appropriate and to make corrective changes as necessary.

The Conference Committee report in no way suggests that the Secretary does not have the authority to continue to assess the effectiveness of the current guidelines or to promulgate the specific guideline at issue here. We also note that when the conferees issued their report, no reclassification applications had been adjudicated. Accordingly, the conferees concern that the 85 percent threshold might be too high was expressed before results of the original guidelines were available.

We also believe that the revisions to the wage index guidelines provided in this final rule are consistent with our previous assessment of the purpose of the statute. In our June 4, 1991 final rule with comment period we stated, in part, that we believe "that the geographic reclassifications should be limited to those hospitals which are disadvantaged by their current geographic classification because they compete with the hospitals that are located in the geographic area to which they seek to be reclassified." (56 FR 25469). We also stated in the same section of the final rule that:

We believe that section 1886(d)(10) of the Act addresses those situations where a hospital competes in the same market with hospitals in an adjacent area; that is the hospital is more like the hospitals in an adjacent area than the hospitals in its geographic area. (56 FR 25469)

Both statements reflect our concern that a hospital that is not disadvantaged by its current classification should not be reclassified. In addition, the first indicates that in setting the 85 percent guideline we were establishing a minimum standard; no hospitals which did not compete with hospitals in another geographic area should be reclassified. The first statement also reflects our belief at that time that providing a guideline that provided an appropriate comparison of a hospital's wages to those of hospitals in the area to which it requested reclassification would be sufficient to achieve those goals.

However, from the outset, we have been concerned about the appropriateness of the guidelines. In issuing the September 6, 1990 interim final rule, we noted that we did not have the necessary data to estimate the impact on hospitals and that it was possible the provisions could create effects that were unintended or costly. We specifically requested comments on the reclassification criteria (55 FR 36765). However, the comments received on the interim final rule, which we responded to in the June 4, 1991 final rule with comment, were received before data were available on the impact of the guidelines. We also announced in the June 4, 1991 final rule with comment (56 FR 25470), and repeated in the August 30, 1991 final rule (56 FR 43202), that we planned to evaluate the extent and appropriateness of reclassifications under the original criteria and, if necessary, propose revisions to the guidelines for future application cycles. Thus, we recognized that the original guidelines may not have been sufficient to ensure appropriate reclassifications, and we have made public our intention to refine the criteria if they resulted in reclassifications inconsistent with the goal of the reclassification process.

Thus, we believe that we have not only the statutory authority but also an obligation to evaluate the reclassification criteria based on the latest available data and to refine them as necessary. The new reclassification guideline is "outcome-oriented" only in the sense that it is aimed at ensuring the overall fairness of the prospective payment system for all affected hospitals. The 108 percent threshold was not an arbitrary figure selected in order

to achieve a preconceived number of reclassifications that HCFA deemed satisfactory. Rather, the 108 percent threshold is consistent with our view that, in order to qualify for reclassification, a hospital's wage level should be out-of-line with the level reflected in its current wage index and comparable with the average for the area to which it requests reclassification.

The 108 percent standard we are adopting is based on our analysis of hospitals reclassified for the wage index by the MGCRB in its first year of operation. Our analysis demonstrates that 36 percent of the reclassified hospitals had wages that were less than 100 percent of wages in the area from which they were reclassified. An additional 35 percent had wages that were less than 108 percent of, or one national standard deviation above, their old area. Our analysis indicates that hospitals may be reclassified under the current wage guidelines even though, as evidenced by the relationship between their average hourly wages and the wage index value for the area in which they are located, they may not be significantly disadvantaged by remaining in their original labor market area. Our goal is not to achieve a targeted number of reclassifications but instead to insure that hospitals which are reclassified are both significantly disadvantaged by their original labor market area, and similar to the area into which they are reclassified.

Comment: Several commenters stated that the statistical methods for determining the 108 percent threshold are unreasonable and based on potentially inaccurate assumptions. They believe that it is not appropriate to apply a national average standard to individual labor market areas. A few commenters suggested that we use area-specific standard deviations.

Response: These comments address two related, but different issues. The first issue is whether the qualifying standard should be national or area-specific, and the second is how the standard should be established statistically. Regarding the first issue, we believe that, since the geographic reclassification process is applied on a national basis, it is appropriate to develop a standard that can be applied to all hospitals in a consistent and uniform manner. A national standard based on the average variation in wages across all areas meets this objective; area-specific standards do not. The use of area-specific standards would mean that a hospital whose wages are only 3 percent higher than its area average

may qualify for reclassification, while a hospital in a different area whose wages are 10 percent higher than its area average may not qualify. Thus, we believe that a uniform national standard is required to avoid inequities across areas that would necessarily arise if area-specific standards were used.

Second, we developed the national standard threshold using the standard deviation, across all wage areas, of the ratio of a hospital's hourly wage to the average hourly wage for its area. The standard deviation depends in part on the number of hospitals used in its calculation. Area-specific standards would be much more sensitive to differences in the number of hospitals across labor market areas than is the national standard. We want to minimize the effect of variation across areas in the number of hospitals because it should not be a factor that influences the criteria for whether a hospital qualifies for reclassification. We believe that the national standard deviation addresses this issue appropriately.

In summary, in devising the national standard threshold, we wanted a threshold based on relevant data, that was not arbitrarily selected, and that could be applied uniformly to hospitals across all wage areas. The standard deviation, across all wage areas, of the ratio of a hospital's hourly wage to the average hourly wage for its area meets all of these objectives. It is based on data that compares a hospital's own wage level to the average for its area. To determine the actual threshold in a non-arbitrary manner, we used the standard deviation as a reasonable measure of divergence between a hospital's own wage level and the average for its area. Finally, we based the threshold on national data from all wage areas because we wanted a standard that could be applied uniformly to all hospitals. The use of the standard deviation, as well as the choice of the mean plus one standard deviation for the threshold, are based on the considerations described above and not on the basis of statistical inference.

Comment: Many commenters suggested that the hospital's own wages be excluded from the area average for purposes of making the 108 percent comparison. One statistician took issue with our methodology, stating "that comparing an individual measurement with summary statistics computed with that measurement deleted from the data set is more appropriate for determining whether it is out of line." Some commenters suggested that the 108 percent standard was inappropriate for single hospital MSAs because it would

be impossible for the hospital to have an hourly wage that was 108 percent of itself.

Response: The purpose of the reclassification guidelines is to address only those situations in which a hospital is clearly disadvantaged by its wage index value under the existing labor market definitions. The 108 percent threshold is used to determine whether the average hourly wage that is used in calculating the wage index adjustment with which the hospital is currently being paid adequately represents the hospital's wage costs. Since that hospital's wages are included in the determination of the area wage index, it is appropriate that its wages be included in the area average in order to make a valid determination of whether the hospital is disadvantaged by its current wage index adjustment. Moreover, in establishing the 108 percent threshold, the comparison is not intended to measure whether a hospital's wage data are out of line with the wage data of other hospitals in the labor market area; instead, the comparison is intended to measure whether the hospital's wages are out of line with the wage level used to set the wage index for the hospital's labor market area. Therefore, the wages for the hospital requesting reclassification must be included in its labor market area when applying the 108 percent wage test.

With respect to single hospital MSAs, a hospital in such an MSA receives a wage index value that is based entirely on its own wage data and, therefore, its actual wage levels. Since such a hospital is clearly not disadvantaged by its inclusion in a labor market area where its wage index is determined based on its own wage levels, it is appropriate under this guideline that a hospital should not be reclassified if it is the only one in its area.

However, we note that a hospital that is the only hospital in its county may qualify for reclassification under the guidelines applicable to hospital groups. Since the guidelines for group appeals are based on demographic criteria as opposed to individual hospital guidelines, hospitals applying as a group are not required to meet the wage comparison to its own labor market area.

Comment: A commenter believes that the standard deviation should be taken to four decimal places (or, in percentage terms, two decimal places) in order to replicate the number of decimal places used in the wage index values.

Response: We do not believe that it is appropriate to use four decimal places in the standard deviation (and the mean

to which it is added in order to develop the 108 percent guideline). We believe it is appropriate to use four decimal places in the wage index but not in the standard deviation because the wage index values are used for specific payment purposes to individual labor market areas whereas the standard deviation is a threshold applied to all areas. We also note that the standard deviation is 12.47 percent, and the mean is 96.04 percent; therefore, taking the values to four decimal places would only increase the standard from 108 percent to 108.51 percent. Any numerical standard will necessarily result in some hospitals just qualifying and others just missing qualification, regardless of the number of decimal points used.

Comment: Several commenters suggested using different numerical standards than 108 percent, with many suggesting using 100 percent of the original labor market area as the threshold. Another commenter suggested deleting the requirement that a hospital pay wages that are at least 108 percent of its original labor market area and instead requiring that a hospital must pay wages that are at least 100 percent of the area to which it requests reclassification.

Response: As discussed in the June 4, 1992 proposed rule (55 FR 23635), before proposing the 108 percent standard for the hospital's original labor market area, and the 84 percent standard for the area to which the hospital requests reclassification, we examined two other options. One of these options was to adopt a 100 percent standard for the hospital's original labor market area. We rejected this option because we believe that a hospital that receives a wage index adjustment based on 100 percent of its own wages is not significantly disadvantaged by its current classification. While the wage index value for those hospitals that pay more than 100 percent, but less than 108 percent, of the average wage levels of their original labor market area, does not fully represent their actual wages, our analysis indicates that these hospitals incur wage costs within the normal range of wage variation within a labor market area. Since the wage index value is based on average wages in an area, it is expected that some hospitals necessarily will have wages above the average but still within the normal range. We have defined the normal range as within one national standard deviation of the average hourly wage. We believe that the new criterion is necessary to ensure that only those hospitals disadvantaged by their current labor market area are reclassified.

Increasing the threshold for the comparison with the area to which a hospital is seeking reclassification and eliminating the comparison with the hospital's own labor market area does not achieve this goal.

Comment: A few commenters objected to the 108 percent guideline because they believe that it rewards inefficient hospitals that have not held their labor costs down. They believe that the new guideline will encourage hospitals that are close to the threshold to increase their labor costs in order to qualify for reclassification.

Response: The 108 percent threshold is not designed to reward inefficient hospitals, but rather to ensure that a significant difference in wages exists before reclassification is permitted. Because of the time lag between the data used to determine reclassification and the benefits of receiving reclassification, we do not believe that hospitals will raise their wages in order to qualify for reclassification. For example, we anticipate using 1990 cost report data to construct the wage index for FY 1994.

Comment: A number of commenters stated that the new wage index criterion applicable to individual wage index reclassifications should also be applied to group applications for reclassification.

Response: We did not propose applying the new wage criterion to group appeals because these applications involve the reclassification of all hospitals in a county to an alternative urban area. Since group applications are based on the interrelationship of geographic areas rather than the relationship of an individual hospital to a given labor market area, all hospitals in the area receive reclassification for all payment purposes, not just the wage index. This is similar to reclassifications provided under section 1886(d)(8)(B) of the Act where hospitals located in a rural county that meets certain specific geographic requirements are deemed urban and receive the urban standardized amount as well as the urban wage index.

For example, the requirements for rural to urban group reclassifications are that the county in which the hospitals are located must be adjacent to the area to which they seek reclassification; must comply with certain MSA guidelines related to commuting and population; and must demonstrate that, as a group, the hospitals pay wages that are at least 85 percent of the average for the area to which they request redesignation. Guidelines for urban to large urban group reclassifications have similar

geographic and wage requirements with an additional standardized amount guideline.

Since group applications are primarily based on commuting and population requirements that apply to an entire area as opposed to individual hospitals in an area, and hospitals are reclassified for all prospective payment system purposes, we do not believe hospitals in a group appeal should be required to meet an additional criterion related to their current labor market area. The wage index criterion and, in the case of urban to urban group applications, the standardized amount criterion are intended to demonstrate that in addition to the county's geographic connection to the adjacent urban area, the hospitals in the county are also similar economically to hospitals in the adjacent urban area both in terms of its average wage levels and overall average hospital costs per discharge. Therefore, we are maintaining without modification the wage criterion for hospitals applying for reclassification as a group (that is, that the average hourly wage for the group must be at least 85 percent of the average for the area to which they are seeking reclassification). However, given the demographic nature of the group reclassification guidelines, we will review the appropriateness of those guidelines in light of any refined labor market area definitions that may be adopted in the future.

Comment: A number of commenters stated that the use of the 108 percent threshold without consideration of occupational mix is contrary to section 1886(d)(10)(D)(i)(I) of the Act, which states that the guidelines established by the Secretary shall include "guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified." These commenters believe that the language in the statute clearly precludes any wage comparison unless an occupational mix adjustment is also provided. The commenters believe that either the 108 percent threshold should be deleted or an occupational mix adjustment should be permitted when comparing the hospital with its own labor market area.

Response: We do not believe that the statute requires that any wage comparison included in the guidelines would be limited to those that include an occupational mix adjustment. Rather, we believe that Congress intended that, in devising the guidelines, the Secretary would consider taking into account a hospital's occupational mix, where appropriate. Further, we do not believe the statute precludes comparisons using

the average hourly wage costs that are actually used to develop the wage index.

Consistent with our interpretation of Congressional intent, the initial guidelines for individual hospital reclassifications for purposes of the wage index provided for two bases of comparison: one on the basis of the hospital's average hourly wage cost and the other on the basis of the prices that the hospital pays for its labor. Recognizing that the variation in average hourly wages is greater than price level variation because of occupational mix differences, we set the threshold for a hospital that wishes to be compared on the basis of labor prices at a higher level than the threshold for a hospital that wishes to be compared on the basis of its average hourly wage. We set the threshold for the labor price comparison at 90 percent since we would expect the hospital to pay a comparable price for labor as hospitals in the area to which it is requesting reclassification.

Based on public comment, we have carefully considered the issue of whether the wage comparison with the hospitals in the original market area should also include an occupational mix adjustment. We believe that, if we were to institute such a provision, any hospital that requests reclassification based on an occupational mix adjustment in one labor market area should base its request on occupational mix adjustments for both labor market areas. For example, we considered whether to provide that a hospital electing the labor price comparison would be reclassified if its occupational-mix adjusted average hourly wage were at least 114 percent of the average hourly wage for its original labor market area and at least 90 percent of the average hourly wage for the area to which it requests reclassification. This provides the same 2 standard deviation band as for the labor cost comparison, since the range is 0.5 standard deviations below the mean to 1.5 standard deviations above. Just as is the case with the 90 percent threshold, we believe a more stringent threshold would be appropriate for a labor price comparison with the hospitals in the original labor market area because the occupational-mix adjusted average wage, which reflects only price differences, is being compared to an average hourly wage that reflects both price and occupational mix differences.

However, we have concluded that requiring an occupational mix adjustment to the wage comparison for a hospital that has elected the labor price comparison with the hospitals in

the area to which it seeks reclassification would not be appropriate because it would result in consequences that are contrary to the intent of the guideline.

Because a hospital's average hourly wage is a function of the mix of labor that it employs and the price it pays for that labor, two hospitals may have the same average hourly wage but one may have a more expensive occupational mix while the other may face higher price levels. Within the same labor market area, the hospitals with higher than average hourly wages tend to have the more expensive occupational mix. The effect of an occupational mix adjustment is to reduce the average hourly wage for hospitals with a more expensive skill mix and to increase the

average hourly wage of hospitals that have a less expensive occupational mix.

The 90 percent threshold allows a hospital to qualify for reclassification that has a lower occupational mix than the hospitals in the area to which it is requesting reclassification. Although a hospital requesting reclassification based on a labor price comparison would have a lower occupational mix than the hospitals in the area to which it is requesting reclassification, the hospital would not necessarily have a lower occupational mix than the hospitals in the area in which it is located. If an occupational mix adjustment were applied in making the wage comparison for purposes of the 100 percent threshold, a hospital that is significantly disadvantaged by the wage index for its area because of factors that

include a higher occupational mix, may no longer qualify. Instead, a hospital with a lower occupational mix whose average hourly wage is within the normal range of wage variation within a labor market area may qualify.

The following example illustrates this in greater detail. Hospital A and Hospital B both have average hourly wages of \$11.95, but they have different occupational mixes and wage rates. Both are currently located in area X, which has an average hourly wage of \$11.04. Both seek reclassification to MSA Y, which has an average hourly wage of \$14.42. Since 84 percent of \$14.42 is \$12.1128, both hospitals must use the occupational mix guidelines to reclassify for wage index purposes. The occupational mix and wage rates of the hospitals are illustrated below:

Employment category	Hospital A		Hospital B	
	Occupational mix (percent)	Wage rate	Occupational mix (percent)	Wage rate
Administration.....	5	\$32.00	2	\$50.00
Registered nurses.....	30	18.00	8	25.63
LPNs and therapists.....	30	10.00	30	15.00
Clerical.....	15	5.00	20	8.00
Other.....	20	6.00	40	7.00

The wages of the two hospitals, adjusted to the occupational mix of MSA Y, are as follows:

Employment category	Hospital A				Hospital B			
	MSA occ. mix (percent)	×	Hospital wage rate	=	MSA occ. mix (percent)	×	Hospital wage rate	=
Administration.....	7	×	\$32.00	=	2.24	7	×	\$50.00 = \$3.50
Registered nurses.....	35	×	18.00	=	6.30	35	×	25.63 = 8.97
LPNs and therapists.....	40	×	10.00	=	4.00	40	×	15.00 = 6.00
Clerical.....	8	×	5.00	=	0.40	8	×	8.00 = 0.64
Other.....	10	×	6.00	=	0.60	10	×	7.00 = 0.70
Total.....					\$13.54			\$19.81

Since 90 percent of MSA Y's average hourly wage is \$12.98, both hospitals satisfy the 90 percent threshold for reclassification to MSA Y for wage index purposes. One hundred eight percent of the average hourly wage for

area X is \$11.9232. Both hospitals would therefore qualify to be reclassified for wage index purposes to MSA Y. If, however, we added the requirement that any hospital that uses occupational mix to qualify for reclassification to a new

labor market area also must use occupational mix to prove that its wages are significantly different from its original labor market area, only hospital B would qualify:

Employment category	Hospital A				Hospital B			
	Area X occ. mix (percent)	×	Hospital wage rate	=	Area X occ. mix (percent)	×	Hospital wage rate	=
Administration.....	4	×	\$32.00	=	1.28	4	×	\$50.00 = \$2.00
Registered nurses.....	16	×	18.00	=	2.88	16	×	25.63 = 4.10
LPNs and therapists.....	40	×	10.00	=	4.00	40	×	15.00 = 6.00
Clerical.....	15	×	5.00	=	0.75	15	×	8.00 = 1.20
Other.....	25	×	6.00	=	1.50	25	×	7.00 = 1.75

Employment category	Hospital A				Hospital B			
	Area X occ. mix (percent)	×	Hospital wage rate	=	Area X occ. mix (percent)	×	Hospital wage rate	=
Total				\$10.41				\$15.05

Since 114 percent of the Area X's average hourly wage is \$12.5856, only Hospital B would qualify. As a result, two hospitals in the same labor market area with the same average hourly wage would be treated differently under an occupational mix guideline for the home labor market area average hourly wage.

We believe it is more important for the hospital that is significantly disadvantaged by its wage index to qualify for reclassification than one that is not. The hospital with the less expensive labor mix is already receiving, through its wage index value, the benefit of being included with hospitals that have average wages that reflect a higher skill mix of employees. We concluded that an occupational mix adjustment would be counter to the purpose of the guideline, which is to identify those hospitals that are significantly disadvantaged by their wage index value. Therefore, we have decided not to add an occupational mix adjustment to the threshold for a hospital that has elected a labor price comparison with the hospitals in the area to which it requests reclassification.

Comment: Several commenters addressed the impact of the budget neutrality adjustment. Some commenters suggested limiting the impact of the budget neutrality adjustment on urban hospitals by obtaining additional funding from Congress to pay for the reclassifications. Other commenters suggested limiting the budget neutrality adjustment to the MSAs directly involved in urban to urban reclassifications, and computing the budget neutrality adjustment on a State-by-State basis.

Response: While we share the commenters' concern about the impact of the budget neutrality adjustment on urban hospitals, we do not agree that the reclassifications granted by the MGCRCB require additional funds. Each year Congress establishes an update to the standardized amount to Health Subcommittee voted to approve the revised guidelines in H.R. 5502, the Health Care Cost Reduction and Reform Act of 1992, which would institute the new guidelines for FY 1993.

Response: Absent final legislative action and Congressional grant of authority, we may not make retroactive

changes to the MGCRCB regulations. Moreover, absent Congressional direction to make a retroactive change, we do not believe that it would be appropriate in this instance to apply the new threshold retroactively. FY 1993 reclassifications have been duly granted by the MGCRCB based on guidelines in effect at the time decisions were made and therefore should be implemented.

Comment: Some commenters suggested a 2-year phase-in of the new wage guideline.

Response: The commenters did not explain what they intended by a 2-year phase-in. One type of phase-in would be to spread the payment redistribution effect of the reclassification change over 2 years. We do not believe we have authority to provide for this type of phase-in because hospital payments are based on geographic location. Unless a hospital receives reclassification to another area, we do not have the authority to provide additional payments to non-reclassified hospitals.

Another type of phase-in would be to move from a 100 percent threshold in the first year to a 108 percent threshold in the next. However, this would not phase in the redistribution effect for a reclassified hospital since it would allow one group of hospitals to continue to be inappropriately reclassified for an additional year and not allow other hospitals to do so. In our view, a hospital is either appropriately reclassified or it is not, and payment should be made accordingly. It would not be appropriate to provide additional payments to hospitals that are inappropriately reclassified through the reduced payments to urban hospitals. Moreover, since the new guideline will not affect hospital payments until FY 1994, we believe the delayed implementation date is sufficient to allow hospitals to adapt to the change.

Comment: Some commenters suggested that instead of instituting the 108 percent wage test, we should simply limit the number of hospitals eligible for reclassification by restricting the program to rural hospitals or by allowing urban hospitals to reclassify for wage index purposes only. Other commenters suggested giving special consideration to certain types of hospitals such as rural hospitals with over 225 beds. One hospital suggested

"grandfathering in" hospitals already reclassified and applying the new threshold only to new applications. One commenter suggested that we limit reclassifications only to those hospitals where the payment effect was greater than 3 percent.

Response: Under the statute, we do not have the authority to deny both wage index and standardized amount reclassifications to any prospective payment system hospital because of its location if it otherwise meets the required guidelines. Section 1886(d)(10)(C)(i) of the Act requires that the MGCRB consider the application of any prospective payment hospital that requests that the Secretary change the hospital's geographic classification for purposes of determining the hospital's standardized amount or wage index. Therefore, an urban hospital should not be limited to reclassification for its wage index only.

We do not believe it is appropriate to institute special wage guidelines for certain classes of hospitals, such as large capacity rural hospitals, nor to limit the types of hospitals that can be reclassified. Further, it would be inappropriate to "grandfather" hospitals that cannot meet the revised guideline. The statute is clear in the requirement that reclassifications are for a period of 1 year, and there is no implication that reclassification would be permanent. Moreover, as discussed above, we announced in previous **Federal Register** documents that we intended to reevaluate the reclassification guidelines and revise them if necessary. Accordingly, we believe it would be unfair to use two different standards for reclassification decisions, depending upon whether a hospital applied in a prior year. To do so would conflict with the purpose of the MGCRRB provisions by allowing some hospitals to be reclassified even though they are not significantly disadvantaged by their current wage index.

Comment: Some commenters believe that the proposed 108 percent standard does not reflect the statutory directive to develop guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services to

Medicare beneficiaries. The commenters maintained that Congress intended that the special access provision result in special consideration for rural referral centers and sole community hospitals, which the 108 percent standard does not provide.

Other commenters recommended that sole community hospitals and rural referral centers be exempt from the 108 percent standard because they must compete with metropolitan hospitals for labor, or alternatively, that they should be subject to a wage threshold of 100 percent rather than 108 percent.

Response: Section 1886(d)(10)(i)(III) of the Act requires that the guidelines include criteria for considering information provided by a hospital with respect to the effect the hospital's geographic classification has on access to inpatient hospital services for Medicare beneficiaries. In drafting the MGCRB guidelines, we gave special consideration to sole community hospitals and rural referral centers with respect to the issue of access to inpatient hospital services for Medicare beneficiaries by waiving the proximity and adjacency requirements for those hospitals. As we stated in our September 6, 1990 interim final rule (55 FR 36762), we believe that the intent of this provision is to ensure continued access to care where a hospital is the sole source of inpatient hospital care or is the only provider of needed tertiary services in rural areas.

We believe that by waiving the proximity and adjacency test for sole community hospitals and rural referral centers we have complied with the directive in the statute to recognize the issue of maintaining access to patient care that these types of hospitals provide. The current access provisions recognize that these types of hospitals, because of their locations in isolated rural areas, may have wages and costs more similar to hospitals in urban areas. Therefore, because of the need to maintain access to inpatient care in those areas, we do not require these hospitals to meet the proximity guidelines. We do not, however, believe it would be appropriate to provide a lower wage standard for sole community hospitals and rural referral centers than for other hospitals applying for reclassification. The issue of whether a hospital is disadvantaged by its current labor market area is equally relevant to sole community hospitals and rural referral centers as it is to other types of hospitals. If a hospital does not pay wages that are out of line with its original labor market area, it is not disadvantaged by its current wage index

value. We see no justification for providing a different threshold for sole community hospitals and rural referral center with respect to the 108 percent comparison. As is the case with the other thresholds applicable to both wage index and standardized amount reclassifications, we believe the 108 percent threshold should be applied consistently to all hospitals.

We remind hospitals that voluntarily terminated their sole community hospital status in favor of geographic reclassification and that anticipate losing that status as of the start of the next or any Federal fiscal year (that is, October 1) that they must reapply for sole community status under the provision of § 412.92(b)(4). Although § 412.92(b)(4)(iii)(A) states that at least one full year must have passed between the effective date of cancellation of sole community status and any future reclassification to that status, we note that all the affected hospitals will meet this criterion as of the date they lose their geographic reclassification. However, § 412.92(b)(2) provides that sole community status is effective 30 days after the date of HCFA written approval. To avoid any loss in special payment status, we encourage hospitals in this situation to reapply for sole community status 3 months prior to the date they anticipate losing geographic reclassification (that is, July 1 of the applicable year). Assuming that a hospital requalifies as a sole community hospital under the current criteria at § 412.92(a), the HCFA regional office will approve the hospital's request effective October 1 contingent upon the hospital reverting to rural status on that date. Although regional offices will process applications as quickly as possible for these hospitals, those that do not submit an application to requalify for sole community hospital status by July 1 may experience a delay in obtaining sole community status.

Comment: One commenter stated that the proposed 108 percent standard would endanger the viability of health care in rural America. The commenter also stated that a rural hospital reclassified only for its wage index would not receive the urban standardized amount, and therefore would still be paid less than an urban hospital. Also, even when the single rate standardized amount payment is adopted, rural hospitals still would have been penalized for several years.

Response: We note that approximately 30 percent of all rural hospitals were reclassified by the MGCRB in FY 1993 for purposes of the wage index. Our analysis indicates that

10 percent of rural hospitals will still be able to qualify for reclassification based on the new wage guideline. Therefore, only 20 percent of all rural hospitals will be impacted by the change. Since 80 percent of all rural hospitals will not be affected by the change, either because they never qualified for reclassification or are still eligible for reclassification, we do not believe that the revised guidelines will have a significant impact on the financial viability of rural hospitals as a group.

Moreover, we note that the benefit of reclassification is diluted for those hospitals that are significantly disadvantaged by their wage index because the wage index value for hospitals reclassified to a given area is reduced as a result of inappropriate reclassifications. For FY 1993, there are 15 reclassified areas listed in table 4c that will be receiving the Statewide rural wage index value because the wage index for their reclassified areas fell below the rural value. Clearly, inappropriate reclassification of hospitals with relatively lower wages is limiting the benefit of reclassification for those hospitals that are disadvantaged by their current labor market area.

We also note that of the hospitals reclassified for FY 1992 by the MGCRB, a higher percentage of the urban hospitals will be affected by this change than rural hospitals. Our analysis indicates that 90 percent of all urban hospitals that were reclassified for their wage index will no longer qualify for reclassification.

Since the inception of the prospective payment system, many programs have been initiated to ensure that the payment system is not biased against rural hospitals. Congress has passed many special provisions to help rural hospitals, such as the gradual phase out of separate standardized amounts, higher annual updates for rural hospitals, and higher disproportionate share payments for sole community hospitals and rural referral centers to provide equity between urban and rural hospitals.

An analysis of hospital profit margins indicates that the differences in profit margins for prospective payment hospitals based on PPS-7 cost report data for urban and rural hospitals has begun to narrow. We expect this trend to continue under current law with the elimination of the differential between the urban and rural standardized amounts.

Comment: Some commenters stated that Medicare policy should encourage a stable payment system from year to year. They believe that instituting

changes to the MGCRB guidelines for FY 1993 applications, and then instituting the revised MSA definitions and potential changes to labor market definitions for FY 1994, is inconsistent with that goal. Commenters suggested that the change in the guidelines be delayed until the revised labor market areas and new MSA definitions are implemented and updated wage data are available. One commenter suggested that HCFA implement the revised MSA definitions for MGCRB decisions in FY 1993 affecting reclassifications in FY 1994.

Response: Since the effects of reclassifications must be budget neutral, increased payments to one group of hospitals are offset by reduced payments to other groups. Accordingly, we believe that we have an obligation to ensure that reclassifications are granted only to those hospitals that truly warrant such reclassification because they are disadvantaged by their original labor market designation. Since our analysis clearly indicated that the current guidelines have resulted in the reclassification of some hospitals that are not disadvantaged by their original labor market designation, we have a responsibility to revise the guidelines in order to improve payment equity across all hospitals. Because the reclassification process is budget neutral, inappropriate reclassifications result not only in increased payments to hospitals that are not disadvantaged, but also in reduced payments to the hospitals that must fund the reclassifications.

We recognize that the revised guidelines may create difficulties for those hospitals that have altered their operations in anticipation of continued reclassification. While we are sympathetic to the impact that the revised guidelines will have on their financial condition, we believe it would be inappropriate to defer any revisions until next year. Since the revised guidelines will not affect payment until FY 1994, hospitals will have time to adjust to their loss of reclassification status. The benefits of providing additional adjustment time to these hospitals must be balanced against continuing to disadvantage non-reclassified hospitals through the budget neutrality adjustment. While we agree that payment stability is important, we have made it clear from the outset that it was our intention to examine the guidelines and propose any changes that were warranted.

Given these considerations, we do not believe it would be appropriate to delay implementing the new wage guidelines

until the revised MSAs and/or labor market area definitions are also implemented. As we indicated in the June 4, 1992 proposed rule, the revised MSA definitions based on the 1990 census will be implemented in FY 1994 at the same time that the MGCRB reclassifications based on revised guidelines will take effect. Updated wage data will be incorporated into the FY 1994 wage index and it is also possible that refinements to the labor market areas will also be implemented at the same time that the MSA definitions are revised. Since these changes will coincide with the implementation of the revised guidelines for payment purposes, they may mitigate the adverse effect on hospitals that no longer qualify for reclassification. Some rural areas will become urban under the revised MSA definitions. In addition, the more recent wage data will help hospitals located in areas where wage levels have risen more rapidly than the national average. Finally, we believe that the revised guidelines will have relevance to any refined labor market area definitions.

Because the revised definitions have not yet been announced by OMB, we cannot adopt the revised MSA definitions in time for the MGCRB's review of reclassification requests during FY 1993. It is not simply a question of recognizing the new MSAs but also a question of reconfiguring the wage data to match those MSAs. However, we note that the new MSAs will be taken into account when we issue the proposed rule for FY 1994. As we stated in the proposed rule (57 FR 23637), in constructing the FY 1994 wage index, it will be necessary for us to group hospitals into their appropriate labor market areas based on the reconfigured MSAs and any other refinements in the labor market area definitions, and to determine where reclassified hospitals should be located.

Comment: A few commenters were concerned about the proportion of labor to non-labor costs in the standardized amounts. These commenters stated that the labor portion of the standardized amount was greater for rural hospitals than urban hospitals and was not consistent with 71.40 percent labor portion stated in the proposed rule (57 FR 23688). These commenters believed that any changes in the MGCRB guidelines should be delayed until the computation of the standardized amount is reevaluated.

Response: The comments reflect a misunderstanding of how the standardized amounts were computed. The urban and rural adjusted

standardized amounts were developed from actual cost data as reported by hospitals on their Medicare cost reports for fiscal years ending in calendar year 1981. We described this methodology at great length in both the September 1, 1983 interim final rule (48 FR 39752) and the January 3, 1984 final rule (49 FR 234). The difference in the proportion of labor versus nonlabor between the urban and rural standardized amounts is a result of the standardization process that occurs after the percentage of the labor-related share is determined based on the hospital market basket. In the current market basket, 71.40 percent of hospital costs are considered to be labor-related. The labor/nonlabor portions derived from the hospital market basket are applied to hospital costs before the standardization adjustments for area wage differences are made. As a result, the labor/nonlabor proportions of the final urban and rural standardized amounts will vary. As described in the rules mentioned above, the labor portion of a hospital's costs is standardized by dividing those costs by the area wage index. The individual standardized costs are combined to derive a single urban or rural standardized amount. Because rural hospitals generally have wage index values less than 1.0 and urban hospitals generally have values greater than 1.0, during the standardization process, the rural labor portion of the standardized amount increases while the urban labor portion decreases. Therefore, while the labor portions of the standardized amounts appropriately reflect the market basket labor component (that is, 71.40 percent of costs), the proportions for the urban and rural rates will vary.

e. Guidelines for a Hospital Seeking Reclassification for Purposes of its Standardized Amount. As discussed in the June 4, 1992 proposed rule (57 FR 23636), we did not propose changing the guideline for individual hospital reclassifications for purposes of the standardized amount.

f. Application of Numeric Standards. In order to ensure consistency throughout the MGCRB adjudicative process, we are modifying the MGCRB regulations in each section where a numeric standard is set forth to specify that rounding is not permitted. No comments were received on the rounding issue, but, as discussed below, we received one comment on the broader issue of numeric standards.

Comment: Some commenters recommended that an exceptions process be established regarding the numeric criteria applied by the MGCRB. They argued that any set of numerical

criteria is arbitrary and that an exceptions process would allow hospitals that do not meet the criteria, but have a justifiable case, to be considered for reclassification.

Response: To fairly assess the merits of reclassification requests, the MGCRB must base its decisions on a consistent, reliable set of criteria that can be applied equally in every case. We believe that objective criteria are necessary to ensure that all hospitals are treated fairly and consistently. Moreover, given the volume of applications, a determination process based on subjective guidelines, such as those necessarily associated with an exceptions process, would likely be very time-consuming and would therefore make it less feasible for the MGCRB to meet the March 30 deadline for issuing decisions. Given the subjective nature of an exceptions process, it would be very difficult for the MGCRB to make individual case-by-case determinations in a consistent and equitable manner. Therefore, we are not providing for an exceptions process at this time. However, we will continue to evaluate the reclassification process to determine if further revisions are appropriate in order to better target reclassifications to those hospitals that warrant reclassifications.

2. Implementation of FY 1994 Hospital Reclassifications

a. *Appropriate Wage Data.* We are revising §§ 412.230(e)(2) and 412.232(d)(2) to clarify that the appropriate wage data are the data used to construct the wage index in effect for prospective payment purposes during the year in which the MGCRB considers the applications. Because the wage data will be updated annually beginning in FY 1994, there will always be a 1-year lag between the wage data used by the MGCRB to make its determinations and the data used to develop the wage index in effect during the year reclassification is effective.

Comment: Several commenters indicated that they do not believe it is appropriate that hospitals are being asked to submit their applications for FY 1994 reclassification based on 1988 wage data. They argue that the 1988 wage data will determine if they qualify for reclassification, while the wage index that will be effective for FY 1994 payments will be based on 1990 wage data and revised labor market areas. Many of the commenters referred to this as the "Blind Leap Rule" because hospitals must make reclassification decisions based on data that will not be a factor when the reclassifications take effect. In addition, one commenter

wanted the 1990 wage data to be used if there has been a change of ownership since 1988. Another commenter asked for clarification as to what data will be used for the FY 1994 wage index update. Some of these commenters noted that rural hospitals were disadvantaged by the exclusion of contract labor from the 1988 wage data and suggested that the revised guidelines be deferred until contract labor is incorporated into the average hourly wages.

Response: We anticipate using FY 1990 hospital wage data to construct the updated wage index for FY 1994. While this data is currently being submitted to HCFA through the HCRIS system, a complete database will not be available by October 1, 1992, when the MGCRB begins to consider applications for FY 1994 reclassifications. Moreover, the data currently available on the HCRIS system has not yet been tabulated, edited or reviewed. As we evaluate the data and as additional cost reports are submitted, we expect the data to continue to change until such time that the final wage index for FY 1994 is developed. In addition, the wage data will need to be reconfigured to conform to the revised MSA definitions and any refinements that we make in the FY 1994 labor market areas after proposed rulemaking. Therefore, complete and accurate 1990 wage data consistent with the FY 1992 labor market areas will not be available for use in making wage comparisons with respect to applications considered during FY 1993. The very nature of the reclassification process, which requires hospitals to apply 1 year before the reclassification takes effect, precludes the use of data in the application process that coincide with those that will be used to make payments after reclassifications are implemented. Once the wage data is updated annually beginning in FY 1994, there will necessarily be a 1-year lag between the wage data used by the MGCRB to make its determinations and the data used to develop the wage index in effect during the year reclassification is effective. Accordingly, the MGCRB will continue to use 1988 wage data and FY 1993 labor market areas to determine if a hospital qualifies for a wage index reclassification for FY 1994. These data represent the latest complete database on which valid comparisons can be made across areas.

The issue of contract labor costs is discussed in section III above. However, we note that the reported 1988 contract labor data had such varied and significant problems that to rely upon it would have arbitrarily advantaged some areas and disadvantaged others. Since

the 108 percent threshold will compare a rural hospital to other rural hospitals, it is not clear that the omission of contract labor from the wage index will affect the ability of most rural hospitals to meet this guideline.

Comment: Several commenters were concerned about the process of reclassification for merged hospitals that were previously single entities during the 1988 survey process and suggested that post-merger wage data be used.

Response: Merged hospitals that have been assigned a single provider number must apply jointly to the MGCRB. In recognition of this situation, the MGCRB has a process whereby merged facilities may be considered for reclassification. If both facilities are located in the same geographic area, this is accomplished by combining the wage and/or cost data for the two facilities. The wage survey data is combined by adding the inflation-adjusted salaries and hours of the two facilities together and then dividing the total combined salaries by the total combined hours to obtain a new average hourly wage. Cost data also may be combined by adding the required data of the two facilities together to achieve a combined cost per discharge. The adjustment factor such as case-mix index can be combined based on the discharge-weighted average of the two facilities.

On the other hand, if the hospitals continue to operate as separate providers, a separate reclassification decision will be made for each facility. In either case, the 1988 wage data must be used. There is no provision for adjustment of any wage data for events occurring subsequent to the survey period.

b. *Revised Labor Market Areas.* As noted in section III.E. of this preamble and the response to a previous comment, in FY 1994 we expect to implement revised MSA definitions based on the 1990 census data. The revised labor market areas that will be effective for FY 1994 will be based on the new MSA definitions that will be announced by OMB later this year, as well as any refinements in the labor market area definitions that our analysis indicates would be appropriate. As in the past, we anticipate significant changes to the MSA definitions, including the creation, elimination, or merging of MSAs, as well as the movement of counties from one MSA to another.

OMB is not expected to publish revised MSA definitions until later this year, by which time most or all hospitals may have already submitted their

applications for FY 1994 reclassification. To be consistent and equitable to all hospitals, hospitals that are applying for geographic reclassification effective in FY 1994 will need to base their requests on the current MSA definitions, and the MGCRB will make its determinations during FY 1993 based on the MSA definitions used for prospective payment purposes in FY 1993.

In constructing the FY 1994 wage index, it will be necessary for us to group hospitals into their appropriate labor market areas based on the reconfigured MSAs and any other refinements in the labor market area definitions, and to determine where reclassified hospitals should be located. The proposed rule on the prospective payment system for FY 1994 will provide a detailed discussion of our proposed policies concerning the effects of the new labor market area definitions on the geographic reclassification of hospitals. We note that, as provided in § 412.273(a)(2), a hospital will have 45 days from publication of the FY 1994 proposed rule to withdraw its application for reclassification if it determines that such reclassification would not be advantageous in view of the revised wage data or new labor market areas that will be implemented in FY 1994. The revised MSA definitions will be used by the MGCRB in making determinations for FY 1995 reclassification requests, which must be submitted to the MGCRB by October 1, 1993.

3. Administrative and Procedural Guidelines

a. Withdrawing an Application (§ 412.273). We are revising § 412.273 to specify that a hospital's request for withdrawal of an application must be submitted to the MGCRB. Additionally, we are adding a new paragraph (c) to § 412.273 to provide appeal rights for a hospital whose request for withdrawal has been denied by the MGCRB. A hospital may request that the Administrator review the MGCRB's denial within 15 days of the date of the notice of denial. Within 20 days of receipt of the hospital's appeal request, the Administrator will either affirm or reverse the denial. We received no comment on this specific change and we are adopting the proposed change with a revision to clarify that the 15-day deadline applies to the date of receipt; that is, the hospital's request for review must be received within 15 days of the date of the notice of denial. However, we received one comment concerning

the withdrawal process which we address below.

Comment: One commenter noted that hospitals have 45 days from publication of the annual prospective payment system proposed rule to withdraw their applications for reclassification. The commenter asserted that since changes may occur in the wage index values between the publication of the proposed rule and the final rule, hospitals should be permitted to withdraw their applications within 30 days of the publication of the final rule.

Response: We believe that the proposed rule constitutes the latest feasible resource for providing hospitals with the necessary information to decide whether to withdraw requests for reclassification. We recognize that the proposed wage index values will change slightly in the final rule to take into account the impact of any withdrawal requests and the effect of any decisions by the MGCRB or the Administrator that were not issued in time to be taken into account in the proposed rule. We cannot extend the 45-day deadline, however, because doing so would not provide reasonable time to take withdrawals into account in the development of the final wage index and prospective payment system rates.

We note that although hospitals are permitted to withdraw their applications for reclassification at any time during the 45-day period, even if an MGCRB decision has already been made, a hospital that requests that its application be withdrawn may not request that the MGCRB decision be reinstated after publication of the prospective payment system final rule.

b. Reopening. We are adding a new paragraph (g) to § 412.278 to provide that, within 10 days following a decision issued by the Administrator, a hospital may request that the Administrator amend the decision only to correct mathematical or computational errors, or facial errors. Examples of mathematical or computational errors include, but are not limited to, the erroneous entry of data for the respective cost or wage comparison calculation. An example of a facial error would be a decision that includes incorrect identifying information for the affected hospital(s). The Administrator would promptly review the hospital's request and amend the decision, if necessary, within 5 days following receipt of the hospital's request for amendment. The Administrator, at his or her discretion, may also amend the decision to correct mathematical, computational, or facial errors within 15 days following the issuance of his or her

initial decision. The Administrator's amended decision is final and is not subject to judicial review. In accordance with these changes, we are also revising § 412.278(f)(3) to state that the Administrator's decision issued under §§ 412.278 (a) or (c) is final unless it is amended under § 412.278(g).

Comment: One commenter apparently misinterpreted the republishing of current § 412.278 of the regulations text in the proposed rule as proposing a new provision concerning judicial review of the Administrator's decisions.

Response: In the proposed rule, we republished § 412.278 of the regulations text to correct technical errors in the CFR. The provisions concerning Administrator review were subject to the notice and comment rulemaking process in the September 6, 1990 interim final rule (55 FR 36754) and the June 4, 1991 final rule with comment period (56 FR 25458) and, with the exception of the new reopening provision, have not been materially altered in this rule. We note that section 1886(d)(10)(C)(iii)(II) of the Act specifies that with regard to appeals of MGCRB decisions, "the decision of the Secretary shall be final and shall not be subject to judicial review." Our regulations are consistent with that provision.

c. Technical Changes to § 412.278(f)(1). In title 42 of the Code of Federal Regulations, parts 400 to 429, revised as of October 1, 1991, on page 331, the text of § 412.278(f)(1) was printed incorrectly. The correct text, which describes what evidence the Administrator may consider in reviewing an MGCRB decision on a hospital's reclassification request, was originally published as § 412.278(c) in our September 6, 1990 interim final rule (55 FR 36770) and was redesignated as § 412.278(f)(1) in our June 4, 1991 final rule with comment period (56 FR 25489). In addition, technical changes to paragraph (f)(1) are needed to clarify that the Administrator may review comments submitted by HCFA or a hospital during the appeals and discretionary review process. These changes should have been included in our June 4, 1991 final rule but were inadvertently omitted.

Accordingly, we are revising § 412.278(f)(1) to ensure that this section of the Code of Federal Regulations is correct and to incorporate the necessary references to comments submitted during the appeals and discretionary review process.

V. Other Changes to the Prospective Payment System for Inpatient Operating Costs

A. Outlier Payments (§ 412.82)

1. Background

Section 1886(d)(5)(A) of the Act requires the Secretary to pay an additional amount beyond the basic prospective payment amount for a hospital inpatient case that involves an extremely long length of stay or extraordinarily high costs when compared to other discharges classified in the same DRG. We refer to these atypical cases as "day outliers" and "cost outliers," respectively. Section 1886(d)(5)(A)(iii) of the Act specifies that outlier payments approximate the marginal cost of care beyond the outlier threshold. The purpose of the outlier payment is to protect the hospital from significant financial loss in individual cases.

In the two final rules published on August 30, 1991 that implemented changes to the inpatient operating prospective payment system and a new prospective payment system for capital-related costs for FY 1992 (56 FR 43196 and 43358, respectively), we established a unified outlier payment methodology for capital and operating outlier cases. Under § 412.82, for day outliers, an additional per diem payment is made for each covered day of care beyond the length of stay threshold. The per diem payment is equal to 60 percent of the average per diem payment (operating and capital) for the DRG, which is calculated by dividing the standard payment for that DRG by the geometric mean length of stay for the DRG. The capital portion of the day outlier payment is multiplied by the applicable Federal transition percentage during the transition to a prospective payment system for capital-related costs.

For cost outliers, we pay 75 percent of charges, adjusted to equal capital and operating costs, beyond the cost outlier threshold. Charges are adjusted to cost using hospital-specific cost-to-charge ratios and standardized to eliminate the effects of the indirect costs of medical education and the costs of treating a disproportionate share of low income patients, for both operating costs and capital-related costs. As with day outliers, the capital portion of the cost outlier payments is then multiplied by the applicable Federal blend percentage. Cases that qualify as both day and cost outliers are paid under the methodology that yields the highest combined capital and operating payment.

The current outlier payment methodology reflects refinements that

we have made since the inception of the prospective payment system to improve the financial protection for high cost cases.

2. Changes to the Payment Methodology for Day Outliers

In the August 30, 1991 final rule implementing the prospective payment system for hospital inpatient capital-related costs, we stated that, as part of our ongoing study of possible refinements to outlier payment policy, we would examine whether changes in the marginal cost factors used to determine outlier payments would be appropriate in light of the inclusion of capital in the outlier payment (56 FR 43383). We believe that the marginal cost factor should be set at a level that is appropriate for Medicare cases, and that is based on more recent data for operating and capital costs.

Based on a study by the RAND Corporation and our own analysis which indicated the significant potential for improvements in payment equity across types of outlier cases (see 57 FR 23640), we proposed in the June 4, 1992 rule to revise the day outlier payment policy effective for discharges occurring on or after October 1, 1992. We proposed revising § 412.82(c) to reflect that the per diem payment would be calculated using the arithmetic mean and a 0.55 marginal cost factor. That is, for each DRG the per diem day outlier payment under the prospective payment system for operating costs would be determined by dividing the standard DRG payment by the arithmetic mean length of stay for that DRG, and multiplying the result by 0.55. During the transition to a prospective payment system for capital, the capital portion of the day outlier payment would also be multiplied by the Federal payment blend percentage. (For cost reporting periods beginning in FY 1993, the blend percentage will be 20 percent for fully prospective hospitals, a hospital-specific percentage that reflects the ratio of Medicare inpatient new capital costs to Medicare inpatient total capital costs for hospitals receiving hold harmless payments, and 100 percent for hospitals receiving 100 percent of the Federal rate.)

For cost outlier cases, we pay 75 percent of the charges adjusted to cost beyond the cost outlier threshold. If we were to adopt this same policy for day outlier cases, the marginal cost factor would be set at .40 (.55 × .75) for day outlier cases. As stated in the proposed rule, we considered adopting a 2-year phase-in of this policy by implementing a .50 marginal cost factor for day outliers in FY 1993 and moving to a .40

marginal cost factor in FY 1994.

However, because of the significant impact this change would have on those hospitals with longer lengths of stay that have more day outlier cases than average, we proposed to adopt an incremental change to a .55 marginal cost factor in FY 1993 and evaluate its effects before considering additional revisions to the day outlier payment policy.

After consideration of all comments received on this issue, as discussed below, we are implementing the changes to the outlier payment methodology as proposed.

Comment: Several commenters supported our proposed change in the day outlier payment methodology. ProPAC agreed that this change would result in better targeting of outlier payments to those cases that impose the largest financial burden on hospitals. Other commenters opposed the change, or advocated a 2-year phase-in of the change in order to mitigate its impact on those hospitals with a relatively high proportion of day outlier cases. A few commenters advocated further reductions in payments to day outlier cases by adopting a .40 marginal cost factor for FY 1993, while others suggested that we wait to assess the impact of these changes before contemplating additional reductions. One commenter requested that we publish the information used to determine the reduction in the marginal cost factor for day outlier payments.

Response: As discussed in the June 4, 1992 proposed rule (57 FR 23640), research by the RAND Corporation shows that hospitals receiving day outlier payments are paid more than the marginal costs of caring for these patients during the outlier portion of their stay. As a result, payments for the most costly outlier cases are a smaller proportion of the costs of treating these cases than they would be in the absence of the excessive day outlier payments. The results of the study³ indicate that the change in the calculation of the per diem payment for day outliers will more accurately reflect the marginal cost of treating patients during the outlier portion of their stay. In addition, we note that the hospitals that are most affected by this policy change, those in Region II (hospitals in New York, New Jersey, and Pennsylvania), will continue to have the highest payment-to-cost

³ A technical paper describing the study and the results, Carter, G.M. and Rumpel, J.D., "Payment Rates for Unusual Medicare Hospital Cases", is available from HCFA.

ratio for outlier cases of any payment region after the change is implemented.

We believe that making this change on a phased-in basis would be inappropriate because it would result in continued overpayment for day outlier cases during the phase-in period. Also, it would be extremely difficult to achieve an even phase-in of the redistributive effect of the policy change. Because the change to the arithmetic mean length of stay provides the bulk of the change in distribution of outlier payments, an even transition would require pricing of bills under the old and new payment systems and then averaging the payments. This would be administratively difficult and costly, and would lead to problems in the definition of day and cost outliers, since a case which qualified as a day outlier under the old methodology might qualify as a cost outlier under the new methodology.

We agree that it would be inappropriate to establish further modifications in day outlier policy until we can assess the results of the changes implemented in this final rule. However, we will continue to evaluate possible changes to outlier policy in order to improve our ability to protect hospitals from significant financial loss in individual cases.

Comment: Several commenters believe that the proposed change to the day outlier per diem would result in unfairly shifting payments from major teaching (IME) and disproportionate share (DSH) hospitals to proprietary hospitals. In addition, they stated that there are serious methodological flaws in the cost outlier payment formula that should be corrected before shifting funds from day outlier cases to cost outlier cases. Specifically, the commenters asserted that the use of a single hospital-wide cost-to-charge ratio distorts cost outlier payments. They provided an example that purports to show that departmental cost-to-charge ratios would increase payments to IME and DSH hospitals.

Response: The change in outlier payment policy does not result in the shifting of payments from most major teaching or disproportionate share hospitals. Estimates of the impact of the proposed change indicate that, with the exception of hospitals in Region II, the hospitals receiving DSH or IME payments in no other region will experience a major decline in payments, and most will experience modest increases in total payments. Overall, hospitals in Region II show the largest total payment declines as a result of the change, but they maintain the highest payment-to-cost ratios for outlier cases even after the proposed change. The

effects on the IME/DSH hospitals in that Region are similar. If the outlier change resulted in payment decreases for high DSH hospitals, we would expect it to result in payment decreases for government-controlled hospitals, which tend to provide a relatively large proportion of care to low income patients. However, this is not the case. Overall, the impact on government-controlled hospitals is a 0.0 percent change in total payments (See appendix A to this final rule, Table 1).

The cost-to-charge ratios are determined on a hospital-specific basis, and we do not believe the use of departmental cost-to-charge ratios in lieu of an overall cost-to-charge ratio would have a significant effect since any differential mark-up policies should be captured in the overall cost-to-charge ratios. We believe that the example submitted by the commenters on the effects of using departmental cost-to-charge ratios is based on distorted cost-to-charge data, and that a different methodology would better show the effect of using departmental cost-to-charge ratios on cost estimation. We used the average cost-to-charge ratios for ancillary and routine services as presented by the commenters to develop our analysis. We examined the costs for the same type of case at two hospitals where the total costs were the same when calculated using separate ancillary and routine cost-to-charge ratios. Our analysis showed that the only difference between the costs estimated using the overall cost-to-charge ratio and those estimated using separate routine and ancillary cost-to-charge ratios is due to rounding. However, we plan to analyze the use of separate cost-to-charge ratios for calculating cost outlier payments in time for consideration of the results in developing the FY 1994 proposed rule.

Comment: One commenter suggested that any savings realized through changing the per diem payment calculation for day outliers be used to lower the thresholds for day outliers, rather than lowering the cost outlier threshold.

Response: In establishing the FY 1993 thresholds, we reduced both the day and cost outlier thresholds so that the percentage of cases that qualify as day outlier cases remains about the same. However, a larger portion of these cases will now be paid as cost outliers instead of day outliers. We believe that the payment-to-cost ratios for day outlier cases and for cost outlier cases should be approximately the same. As discussed in detail in the June 4, 1992 proposed rule, we calculated the payment-to-cost ratios of different types

of outlier cases under the current policy and under the proposed policy (57 FR 23641). Under the day outlier policy change, the payment-to-cost ratios are more equal across types of outlier cases, with a range of 0.4891 (for those cases that qualify only as cost outliers) to 0.5667 (for those cases that qualify as both types of outliers and are paid under the day outlier methodology). Under the current policy of using the geometric mean length of stay and a 0.60 marginal cost factor, the range is 0.4773 to 0.8549, for the same types of cases. Even under the new policy, the type of case with the highest payment-to-cost ratio will be paid under the day outlier formula. Thus, we believe that it is appropriate to redistribute some outlier funds from cases paid under the day outlier methodology to cases paid under the cost outlier methodology, since it is these cases that experience greater losses.

Comment: One commenter asserted that the research upon which the revised policy is based is potentially flawed, and urges that we delay implementation of any policy change until the results are confirmed by another researcher. This commenter is concerned with the construction of the cost data used in the study, with the standardization procedure used to remove the effects of the payment adjustments from the costs, and with several statistical issues. These issues include the choice of a linear model in the primary regressions, the use of a single day outlier payment multiplier (equivalent to the marginal cost factor) when a wide range is reported across DRGs in the study, and sample selection issues and sensitivity analysis. Another commenter urged that we use more current data to confirm the results of the RAND study, which was based on FY 1990 charge data and FY 1988 and 1989 cost report data.

Response: We are confident that the research done by the RAND Corporation is accurate and that the policy change is appropriate. The method for calculating the costs of a given case has been used by RAND in numerous studies for HCFA, ProPAC, and independent research purposes, and we believe that it provides accurate results. The standardization procedure is based on the total cost regressions performed for the August 30, 1991 final rule that implemented the prospective payment system for capital-related costs, as explained in detail at 56 FR 43369. Thus, we believe that the standardization process used by RAND represents the appropriate relationships between the payment adjustment factors and the total cost per case. RAND chose the

particular linear specification only after ascertaining that it produced an accurate description of how costs per case increase with the number of outlier days. In addition to an examination of plots of data within individual large DRGs, several alternative specifications were tested as described in the RAND report. A spline formulation was used to determine whether costs increase at different rates in different portions of the outlier part of the stay. As described in the report, the larger coefficient in the spline formulation was only 0.025 higher than the average coefficient. Using the arithmetic mean length of stay rather than the geometric mean length of stay did not affect average estimated cost per outlier day. Medical and surgical DRGs groups have only modestly different coefficients. Thus, the simple linear specification with the arithmetic mean length of stay provides a very close approximation to the cost data. Although RAND reported the R-square for each model, it was not used by RAND to choose among models. Rather, the RAND study shows that the estimate of how costs increase with length of stay is robust across a large variety of model specifications.

As the commenter noted, the RAND study found a range of day outlier payment multipliers across DRGs. However, approximately two-thirds of the DRGs had multipliers between 0.40 and 0.70, or within 27 percent of 0.55 (these figures are calculated using the arithmetic mean length of stay). Although the use of DRG-specific marginal cost factors may be a potentially more accurate method of paying for day outliers, we did not contemplate such a step for reasons of administrative complexity. A finding that a few DRGs had day outlier payment multipliers that are significantly different from 0.55 does not, we believe, contradict the choice of an appropriate single marginal cost factor based on the results of the RAND research. A few DRGs have day outlier payment multipliers significantly different from 0.60, the current factor, as well.

Regarding the issue of sample selection and sensitivity analysis, we believe that the authors of the RAND study have shown that their results are valid in this respect. On page 22 of their study, Table 3.3 shows that the coefficient used to determine the day outlier cost multiplier is almost identical when using the current method of paying cost outliers and when using the alternative fixed loss methodology (that is, a case qualifies as a cost outlier if its standardized costs exceed the DRG

payment amount by a fixed dollar amount, regardless of DRG). The difference between the fixed loss methodology and the current cost outlier methodology is a much larger change in cost outlier policy than any movement in the cost outlier thresholds under the current cost outlier policy that we would contemplate in concert with the day outlier policy change. Therefore, we do not believe that the definition of cost outlier cases under alternative policies could cause a sample selection problem or bias the results of this study.

We have confirmed the results of the RAND study using more recent data. The analysis in the proposed rule at 57 FR 23640 of the payment-to-cost ratios of different types of outlier cases was completed using the FY 1991 charge and hospital-specific data. As we expected, we again found that the payment-to-cost ratios of different types of hospitals and different types of outlier cases become more equal after the policy change. In fact, since our confirmation of the results of the RAND study occurred using a completely different structure (that is, looking at the payment-to-cost ratios of FY 1991 cases under the alternative policies, rather than at the variables examined in the RAND study), we are even more confident of the validity of its results than if we had merely replicated the methodology and results.

Comment: Two commenters opposed the change in outlier policy based on their understanding that cost outlier payments are made only if the day outlier threshold has not been passed. Therefore, they believe that, under the new policy, cases with long lengths of stay would receive lower day outlier payments, and not be eligible for cost outlier payments.

Response: Beginning in FY 1989, all cases are eligible for cost outlier payments if their charges, adjusted to cost, exceed the cost outlier threshold. If a case has also passed the length of stay threshold for day outlier cases, it is paid under the method that yields the higher outlier payment. Therefore, the policy change does not penalize hospitals that have long lengths of stay, since their costly cases with long lengths of stay will continue to be eligible for cost outlier payments.

Comment: A commenter requested that we make available, as quickly as possible, the actual impact of the policy change so that the new payment methodology can be assessed.

Response: We will make every attempt to monitor the results of the policy change, and will make those results public as they become available.

3. Analysis of the Factors that Affected FY 1991 Outlier Payments

As we stated in the proposed rule, we do not believe that it is appropriate to make an adjustment in prospective payment system payments to account for the difference between the estimated and actual FY 1991 outlier payments, just as we have not made adjustments in earlier years (see 51 FR 31525; 52 FR 33048; 53 FR 38508; 54 FR 36500; 55 FR 36077; and 56 FR 43227).

Although actual outlier payments (based on the latest FY 1991 billing data) were 4.24 percent of total standard DRG payments (exclusive of DSH and IME) instead of the estimated 5.1 percent, there was no reduction in total standard DRG payments between the payment per case estimated in the August 30, 1991 final rule and the actual FY 1991 total standard payment per case. As the following table illustrates, the lower outlier payments were more than offset by the increase in standardized amount payments.

	FY 1991 payment per case	
	Estimated	Actual
Average standardized amount payment.....	\$4,414.13	\$4,543.57
Average outlier payment.....	237.36	216.35
Total standard DRG payment per case.....	4,651.49	4,759.92

The average total payment per case increased 2.3 percent over the amount estimated in the FY 1991 final rule. We would expect some increase in the average payment for increases in the case-mix index (CMI). The observed CMI increase was 2.5 percent. After removing the increase attributable to the FY 1991 DRG reclassification changes (see Section II.D.), the net CMI increase is 1.5 percent. Thus, the payment increases attributable to the DRG classification changes offset the payment reductions attributable to lower outlier payments. Moreover, the average increase in payment per case of 2.3 percent exceeds our estimate that real case-mix change was between 1.0 and 1.25 percent.

Comment: Several commenters asserted that section 1886(d)(5)(A)(iv) of the Act requires that actual outlier payments for any fiscal year be between 5 and 6 percent of total DRG payments estimated to be made in that fiscal year. Other commenters stated that we should pay retroactively for any difference between actual and estimated outlier payments. One of these commenters suggested that the adjustment be made

prospectively as part of the update framework. Another commenter disputed our statement that we do not make any retroactive adjustments, since the variables that are the basis for the IME, DSH, and capital payments are subject to change at cost report settlement. Finally, ProPAC opposed any retroactive adjustment, stating its belief that such an adjustment would be contrary to the intent of a prospective payment system.

Response: The statutory requirement under section 1886(d)(5)(A)(iv) of the Act, requires that outlier payments be between 5 and 6 percent of the total payments "projected or estimated to be made" based on DRG prospective payment rates for discharges in that year. This statutory language plainly directs the Secretary to establish outlier payments based on projections and estimates. This is what we did. Of course, amounts that are based on projections may differ, at times, from actual amounts that are determined after the operative events have passed. But Congress did not direct that outlier payments be based on actual amounts of total payments but rather on the projected amounts. Thus, we have met this requirement, for FY 1992 and for all other prospective payment system years, through our estimation process as described in the June 4, 1992 proposed rule. We have met our statutory obligations by making every effort to ensure that we have the best possible data to make our estimate of total DRG and outlier payments when setting the outlier thresholds for a given year.

As ProPAC suggests, the commenters' argument that actual payments must be between 5 and 6 percent of total payments is inconsistent with the nature of a prospective payment system. The adjustment to outlier payments that the commenters propose must be considered in the broader context of the prospective payment system. Moreover, we note that the retroactive adjustments suggested by the commenters could also result in reductions in payments to hospitals in years where the outlier percentage was too high. However, we did not make adjustments in outlier payments in those years that we paid out more in outlier payments than anticipated.

We always use the most current data available at the time we set the outlier thresholds. Sometimes, as in FY 1991, the estimates based on that data result in outlier payment percentages being too low. At other times, the actual outlier payment percentages were too high. Such imprecision is inherent in a system that is required by statute to use estimates.

Thus, in light of the nature of a prospective payment system, and our attempts to estimate outlier payments as accurately as possible, we believe that we have satisfied the statute and that no retroactive adjustment is warranted.

We recognize that some hospital-specific data, such as the ratios used to determine the IME and DSH adjustments and the capital costs used to determine the payment methodology and hospital-specific rate under the capital prospective payment system, are corrected at cost report settlement. However, we do not correct the basic outlier payment amount determined for cost outliers (based on the standardization of charges to costs using the cost-to-charge ratios and IME and DSH adjustments available) at cost report settlement, but maintain the amounts determined based on the adjustment factors and cost-to-charge ratios available at the time the outlier payment was calculated. That is, while the various hospital-specific adjustments are adjusted at cost report settlement, the basic outlier and DRG payment amounts are not. We note that we could not correct the outlier cost standardization process or the thresholds at cost report settlement without repricing all discharges, because some cases that were paid under the day outlier methodology might switch to the cost outlier methodology (and vice-versa), and some cases that did not previously qualify as outliers might do so under revised thresholds or vice versa. We see no contradiction between correcting hospital-specific data relating to the payment adjustments at cost report settlement and not correcting system-wide elements, such as the standardized amounts and outlier thresholds. We agree with ProPAC that retroactive adjustment of the system wide elements would be contrary to the nature of the prospective payment system.

Comment: A commenter urged that we consider the decline in length of stay as a result of technological advancements when setting the outlier thresholds.

Response: The average length of stay, after declining at the beginning of the prospective payment system, has levelled out in recent years. We do not believe that it is advisable to make predictions about changing lengths of stay when setting the outlier thresholds.

4. FY 1992 Outlier Payments

As we stated in the June 4, 1992 proposed rule, we anticipate that FY 1992 outlier payments will be less than the 5.1 percent that we originally estimated when we set the outlier thresholds (57 FR 23645). This is due, in

part, to the fact that the FY 1992 thresholds were set using FY 1990 cases that did not reflect the coding effects of the FY 1991 DRG classification changes. In addition, the first quarter of the FY 1990 data included the effects of catastrophic coverage, for which an adjustment was made in estimating FY 1992 outlier payments. Thus, the considerations involved in analyzing the FY 1992 outlier payments are similar to those involved in analyzing the FY 1991 outlier payments.

Using the FY 1991 cases and the FY 1992 payment data, we currently estimate that FY 1992 operating outlier payments will be approximately 3.84 percent of FY 1992 total DRG payments, and that FY 1992 capital outlier payments will be approximately 3.72 percent of capital DRG payments. (If indirect teaching and disproportionate share payments are included in the calculation, the estimated operating outlier percentage is 4.00 percent.) The 3.84 percent estimate for FY 1992 is lower than the 4.24 actual outlier percentage for FY 1991 largely because of changes in the payment adjustment factors.

Comment: Several commenters stated that we should institute a midyear correction of the FY 1992 outlier thresholds, given our estimate in the proposed rule that FY 1992 outlier payments would equal 3.6 percent of total FY 1992 DRG payments. These commenters also believe that we should institute a midyear monitoring process in order to make corrections to the thresholds in the event that we discover a difference between the estimated and actual outlier percentages.

Response: Section 1886(d)(5)(A)(iv) of the Act requires that outlier payments in a fiscal year be between 5 and 6 percent of the total payments "projected or estimated to be made" based on DRG prospective payment rates for discharges in that year. As explained in an earlier response, this statutory language directs the Secretary to make outlier payments based on estimates. In implementing this provision, we consider the projected total amount of DRG payments for all cases and set the outlier thresholds accordingly.

As ProPAC suggests, we believe that the commenters' argument that actual payments must be between 5 and 6 percent of total payments is inconsistent with the nature of a prospective payment system. This is necessarily a prospective process and the estimates upon which payments are based may prove to be inaccurate. We currently anticipate that FY 1992 outlier payments will fall short of the 5.1 percent level

that we originally estimated when setting the FY 1992 outlier thresholds. Moreover, while our current estimate of FY 1992 outlier payments is approximately \$516 million lower than the estimate of FY 1992 contained in the August 30, 1991 final rule, our estimate for standard payments (DRG payments plus outlier payments) is approximately \$2.1 billion higher and our estimate for total prospective payments is approximately \$2.4 billion higher. However, in other years, the estimates on which outlier payments are based resulted in outlier percentages which were too high.

We used the most recent Medicare discharge and hospital-specific data available to estimate total payments and outlier payments. We do not believe that Congress envisioned we would revise in mid-year any of the estimates of factors used to set prospective payment rates for a given Federal fiscal year. These factors include not only the outlier thresholds, but the market basket rate of increase used to establish the update factors, the recalibration of the DRG rates, and the various required budget neutrality provisions. The market basket rate of increase has been overestimated for the past two fiscal years, but we have not made reductions in the standardized amounts during the year as new estimates of the market basket rate of increase became available. Further, our most recent estimate of the FY 1992 market basket rate of increase is 3.6 percent, or 0.8 percentage points lower than that used to establish the FY 1992 standardized amounts. This represents an additional \$480 million in payment. In addition, although we now have evidence that the DRG recalibration resulted in a 1.0 percent increase in FY 1991 program payments, we have not contemplated a retroactive adjustment in the DRG weights or the recalibration of the budget neutrality adjustment factor. Since these increased payments are built into the DRG weights, FY 1992 payments are \$600 million higher than they would have been if we had not made the changes (prior to taking into account the lower outlier payments). Even taking the estimated outlier shortfall into account, the net difference due to the level of the DRG weights and budget neutrality factors is an increase in payments. Another example is the FY 1992 budget neutrality adjustment to the capital prospective payment system. Based on the most current data available we estimate that in FY 1992 capital payments will be 92.8 percent (instead of the statutorily mandated 90 percent) of Medicare inpatient capital

costs. Taking the phase-in of the capital prospective payment system into account, this represents an additional \$90 million in program payments. Taken together, these differences between the original estimates and our most recent projections net to more than \$570 million in excessive Medicare payments for FY 1992.

We do not believe it would be appropriate to make these mid-year corrections given the requirements under sections 1886(d)(6) and 1886(e)(5)(B) of the Act that we publish annual prospective payment rates and update factors by September 1 of each year. First, this provision is meant to provide hospitals with advance notice of the rates that will be in effect for the fiscal year. Second, as a practical matter, any mid-year correction to the prospective payment rates and adjustment factors would have to remove any anticipated payments in excess of our total payment target in order to maintain budget neutrality. Of necessity, any midyear correction would also rely on estimated data that may not be representative of the entire fiscal year. We note, for example, our estimate of FY 1992 outlier payments is based on FY 1991 MEDPAR data and has increased from 3.6 to 3.84 percent between the June 4, 1992 proposed rule and this final rule.

While we do not believe midyear corrections are appropriate, we will explore whether there are methodological changes that we could make in the rate-setting process that would improve the accuracy of our payment projections in the future. One area we will examine is whether it would be feasible and appropriate to incorporate more recent claim data into our projections. Although these data would be limited using available data from the fiscal year immediately preceding the fiscal year for which the rates are effective may improve the projections by capturing more quickly the effects of changes in case mix on payments. If we determine that using limited data from a more recent period would improve the rate calculations, we would propose methodological changes through the rulemaking process. Any changes would be effective no earlier than FY 1994.

Comment: A few commenters stated that our observation that FY 1992 DRG payments are projected to be higher than originally expected is irrelevant when determining whether or not to adjust the FY 1992 thresholds. The commenters believe that we have not demonstrated that the higher DRG payments were inappropriate, and that

overall budget neutrality does not ensure that individual hospitals will not be harmed.

Response: While we are unable to isolate the effect that coding improvements in response to the FY 1991 DRG classification changes had on outlier payments, we are confident that at least a portion of the difference between actual and estimated outlier payments is due to the classification changes. If we had been able to predict the effect of the coding improvements on the distribution of cases across DRGs, we would have taken that effect into account when setting the outlier thresholds and budget neutrality factors. Similarly, we believe that at least a portion of the difference between estimated and actual payments at the individual hospital level was in fact a result of increases in payments based on the standardized amount. Cases that would have received an outlier payment in FY 1990 received higher standardized payments instead. The observation that FY 1992 DRG payments will be higher than originally estimated is not irrelevant. Since total payments to hospitals are higher than anticipated, hospitals as a whole are not harmed by the difference between our original and current estimates of FY 1992 outlier payments.

Comment: A commenter urged that we make available all data from all years of the prospective payment system that would enable the public to analyze any differences between estimated and actual outlier and total payments.

Response: We presented comparisons between estimated and actual outlier payments in the June 4, 1992 proposed rule, at 57 FR 23644. We believe that this is sufficient data to analyze differences between estimated and actual outlier payments under the prospective payment system.

5. FY 1993 Outlier Thresholds

For FY 1993, we proposed to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 23 days or 3 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or \$34,500. The thresholds that we are establishing in this final rule are: for day outliers, the geometric mean length of stay for each DRG plus the lesser of 23 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or \$35,500. The thresholds we would have implemented in this final rule if we were not implementing the change in day outlier payment methodology discussed

above would be: for day outliers, the geometric mean length of stay for each DRG plus the lesser of 27 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or \$39,000.

The FY 1993 outlier thresholds will result in a slight increase in the proportion of outliers paid as cost outliers relative to those paid as day outliers. We estimate that 57.8 percent of cases will be paid using the cost

outlier methodology and 42.2 percent will be paid using the day outlier methodology, compared to 57.8 percent of cases being paid using the cost outlier methodology without the FY 1993 day outlier payment change. Cases that meet the day outlier threshold but that will be paid using the cost outlier methodology, because it yields the higher payment, will increase from 13.9 percent to 17.4 percent of all outlier cases under the final policy. Our simulation of FY 1993 outlier payments based on FY 1991

MEDPAR data indicates that the percentage of outlier cases that will qualify as day outliers is about 75.2 percent under this final policy. The cases qualifying as day outliers will receive 77.2 percent of operating outlier payments in FY 1993. An estimated 24.8 percent of outlier cases will be cost-only outlier cases, which will receive about 22.8 percent of operating outlier payments under this final policy. The following table illustrates this finding in greater detail:

Type of outlier	Percentage of outlier cases		Percentage of operating outlier payments		Percentage of capital outlier payments		Percentage of total outlier payments	
	Current policy	New policy	Current policy	New policy	Current policy	New policy	Current policy	New policy
Meets day threshold only	46.6	48.6	24.6	19.7	24.4	19.8	24.6	19.7
Meets day and cost thresholds, paid using day methodology	11.2	9.2	21.1	14.2	20.9	14.3	21.0	14.2
Meets day and cost thresholds, paid using cost methodology	13.9	17.4	31.8	43.2	30.4	41.4	31.6	43.0
Subtotal—All cases meeting day threshold	71.8	75.2	77.5	77.2	75.8	75.5	77.3	77.0
Meets cost threshold only	28.2	24.8	22.5	22.8	24.2	24.5	22.7	23.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a slightly lower percentage of outlier payments for capital-related costs as for operating costs. We estimate the final thresholds for FY 1993 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.0 percent of capital payments based on the Federal rate.

The final outlier adjustment factors that will be applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Urban standardized amount	Rural standardized amount	Capital Federal rate
0.944598	0.978420	0.9496

6. Other Changes Concerning Outliers

We proposed to remove certain provisions of § 412.82 that are now obsolete. One provision in § 412.82(c) sets forth the factors to be used to compute day outlier payments during the transition period to the prospective payment system for inpatient hospital operating costs. It applied to cost reporting periods beginning before October 1, 1987 and is no longer applicable. We also proposed to remove § 412.82(d). This provision was implemented to conform our regulations to section 4008(d)(1)(A) of Public Law 100-203, which directed the Secretary to compute day and high cost outlier

payments for burn cases using a marginal cost factor of 90 percent in place of the 60 percent and 75 percent factors we used to calculate day and high cost outlier payments for other types of cases. Section 4008(d)(1)(A) was effective only for discharges occurring on or after April 1, 1988 and before October 1, 1989. Unlike payments for high cost, burn outliers, we did not continue to use a 90 percent marginal cost factor to compute payments for day outlier burn cases following expiration of the statutory provision. Therefore, we proposed to delete § 412.82(d) since it is no longer applicable in determining day outlier payments. We received no comments on these changes and are implementing both of them in the final rule.

Because of the change to the calculation of day outlier payments, we are now including the arithmetic mean length of stay in Table 5 of section IV of the addendum to this final rule. When we recalibrate DRG weights, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight and geometric mean length of stay. DRGs that do not have at least 10 cases are considered to be low volume DRGs. For the low volume DRGs, we use the original geometric mean lengths of stay. In order to calculate day outlier payments for cases in DRGs that contained fewer than 10 cases in FY 1991, we are using the original geometric mean length of stay, because no arithmetic mean length of

stay was calculated based on the original data.

Table 8a in section IV of the addendum to this final rule contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1992, these Statewide average ratios replace the ratios published in the August 30, 1991 final rule (56 FR 43196). Table 8b contains comparable Statewide average capital cost-to-charge ratios. These average ratios will be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.311473 or greater than 0.632770 and capital cost-to-charge ratios lower than 0.013573 or greater than 0.259693. This range represents 3 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. The cost-to-charge ratios in Tables 8a and 8b would be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1993.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a

rural referral center (that is, payment is based on the other urban payment rate rather than the rural payment rate). One of the criteria under which a rural hospital may qualify as a referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital is classified as a rural referral center if its—

- Case-mix index is equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and

- Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (We note that the number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. In determining the proposed national and regional case-mix index values, we followed the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value included all urban hospitals nationwide and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

The values in the proposed rule were based on discharges occurring during FY 1991 (October 1, 1990 through September 30, 1991) and include bills posted to HCFA's records through December 1991. Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1992, a hospital's case-mix index value for FY 1991 must be at least—

- 1.2791; or

- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located. (See table set forth in the June 4, 1992 proposed rule at 57 FR 23647.)

Based on the latest data available (through June 1992), the final national case-mix index value is 1.2760 and the median case-mix values by region are as follows:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT).....	1.1852
2. Middle Atlantic (PA, NJ, NY).....	1.1878
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	1.2838
4. East North Central (IL, IN, MI, OH, WI).....	1.2063
5. East South Central (AL, KY, MS, TN).....	1.2125
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	1.1985
7. West South Central (AR, LA, OK, TX).....	1.2561
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	1.3256
9. Pacific (AK, CA, HI, OR, WA).....	1.2818

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1991 case-mix index values in Table 3c in section IV of the addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

We received no comments on this issue.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii)(II) of the Act, the national standard is set at 5,000 discharges. However, we proposed to update the regional standards. The final regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1990 (that is, October 1, 1989 through September 30, 1990). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or

after October 1, 1992, the number of discharges a hospital must have for its cost reporting period that began during FY 1991 would have to be at least the lesser of—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See table set forth in the proposed rule at 57 FR 23647.)

Based on the latest discharge data available, the final median numbers of discharges for urban hospitals by census region are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT).....	7,405
2. Middle Atlantic (PA, NJ, NY).....	8,250
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	6,922
4. East North Central (IL, IN, MI, OH, WI).....	7,581
5. East South Central (AL, KY, MS, TN).....	5,676
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	5,696
7. West South Central (AR, LA, OK, TX).....	4,961
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	8,753
9. Pacific (AK, CA, HI, OR, WA).....	5,636

We reiterate that to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1992, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1991 would have to be at least 3,000.

We received no comments on this issue.

3. Retention of Referral Center Status

The Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239) was enacted on December 19, 1989. Section 6003(d) of that Act states that any hospital that was classified as a referral center as of September 30, 1989, including those so classified as a result of section 9302(d)(2) of Public Law 99-509, would continue to be classified as a referral center for cost reporting periods beginning on or after October 1, 1989 and before October 1, 1992.

In the proposed rule, we stated that, with the expiration of the requirement of section 6003(d) of Public Law 101-239 on October 1, 1992, we would implement the retention criteria and methodology specified in § 412.96(f) that we had developed previously. These criteria and methodology were discussed in the June 10, 1985 proposed rule (50 FR 24380), in the September 3, 1985 final rule (50 FR 35676) and in the September 1, 1989 final rule (54 FR 36486).

Basically, to retain status as a referral center, a hospital will have to meet the criteria for classification as a referral center specified in § 412.96(b)(1) or (b)(2) or (c) for 2 of the last 3 years or it must qualify on the basis of the requirements for the current year. A hospital may meet any one of three sets of the specific criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96(c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital will have to meet all of the criteria within any applicable section of the regulations in order to meet the retention criteria for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(b)(2) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards will have to be met in the same year.

In accordance with § 412.96(f)(2), the review process will be limited to the hospital's compliance during the last 3 years. Thus, if for at least 2 of the last 3 years or for the current year a hospital meets the criteria for FY 1993 outlined above in section V.C.1 and 2 of this preamble, it will retain its status for another 3 years. No hospital will be subject to a review until the end of its third full cost reporting period as a referral center. We have constructed the following chart and example to aid hospitals that qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1993, a hospital must meet the mandatory criteria in § 412.96(c) for FY 1993 or it must meet the criteria for 2 of the last 3 years as follows.

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the Federal Register on
1992	1990	1990	August 30, 1991.

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the Federal Register on
1991	1989	1989	September 4, 1990.
1990	1988	1988	September 1, 1989.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1988. The hospital has fewer than 275 beds. Its status as a referral center is protected through June 30, 1993 (the end of its cost reporting period beginning July 1, 1992). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1990, July 1, 1991, and July 1, 1992. The hospital must meet the criteria in effect for either its cost reporting period beginning July 1, 1993 or for two out of the three past periods. For example, to meet the criteria at § 412.96(c)(2) for its cost reporting period beginning July 1, 1991, the hospital's case-mix index value during FY 1989 must have equalled or exceeded the lower of the national or the appropriate regional standard as published in the September 4, 1990 final rule. The hospital's total number of discharges during its cost reporting year beginning July 1, 1989 must have equalled or exceeded 5,000 or the regional standard as published in the September 4, 1990 final rule.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96 (b)(1), (b)(1)(i) and (b)(1)(ii) (that is, rural location and appropriate bed size (500 or more beds for discharges occurring before April 1, 1988 and 275 or more beds thereafter)), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the bed size criterion used to determine a hospital's initial status as a referral center because we believe it is important for a hospital to demonstrate that it has maintained at least 275 beds throughout its entire cost reporting period, not just for a particular portion of the year.

Comment: Several commenters suggested delaying implementation of the rural referral center triennial review procedure indefinitely or postponing it for at least 2 years when there will no longer be separate other urban and rural standardized amounts. The commenters stated that this would allow current

rural referral centers to continue to receive the payments that they have been receiving and prevent those hospitals that would lose their rural referral center status from having to modify services because of a temporary reduction in their Medicare payments. One other commenter, noting that proposed legislation extending the grandfathering provision is pending in Congress, requested that we postpone implementation of the triennial reviews until Congress adjourns in October.

Response: We continue to believe that it is equitable and reasonable to review periodically rural referral centers' compliance with the criteria in the statute and regulations to ensure that only those hospitals that are truly functioning as rural referral centers receive the special adjustment. Some hospitals qualified as rural referral centers based on their case-mix index values and number of discharges from 1981 and have not met the criteria since that time. We believe that the special payment provision extended to rural referral centers should be limited to hospitals that truly warrant such designations based on current conditions. Many hospitals received their classification as a referral center based on conditions that existed many years ago. Thus, we do not agree with the commenters who suggested that we either not implement the triennial review procedures or that we delay implementation for 2 years. Therefore, effective with cost reporting periods beginning on or after October 1, 1992, rural referral centers that do not qualify for an extension will lose their special status. With regard to proposed legislation that would extend the grandfathering provision, we cannot set policy or delay implementing provisions of the regulations based on pending legislation that may be enacted in any one of several forms or may not be enacted at all. If legislation that has an impact on our policy concerning rural referral centers is enacted, we will comply with it as rapidly as possible.

Comment: We received one comment suggesting that since the change in the rural referral center policy will have an impact on payments to hospitals, it should be implemented in a budget-neutral fashion. That is, the money saved from no longer paying these hospitals at the other urban rate should be used to increase the standardized amounts.

Response: It has not been our practice to make budget neutrality adjustments to reflect increases or decreases in aggregate payments due to changes in hospital status for special payment

provisions except when we have been required to do so by the statute. For example, we made a budget neutrality adjustment as required by section 9302(d)(3) of Public Law 99-509 when the rural referral center case-mix index criterion was revised to exclude teaching hospitals effective for cost reporting periods beginning on or after October 1, 1988; however, we did not make subsequent adjustments to the payment rates for additional payments made to newly qualifying referral centers after that date and before the bed-size criterion was lowered, effective April 1, 1988 by section 1886(d)(5)(C)(i)(I) of the Act. Therefore, we do not believe we should adjust the rates when hospitals no longer qualify. We have also taken this position for disproportionate share hospitals, which must qualify annually for additional payments under the disproportionate share hospital provision.

C. Direct Graduate Medical Education Payment (§ 413.86)

Section 1886(h) of the Act sets forth the provisions governing direct payments for graduate medical education. As implemented by regulations at § 413.86, HCFA pays a hospital a fixed amount per full time equivalent (FTE) resident employed by the hospital. Under § 413.86(f), HCFA determines the number of hospital resident FTEs by applying a weighting factor to each resident.

The Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) and the National Board of Medical Examiners Examination (NBME), examinations that a foreign medical graduate must pass in order for a hospital to receive direct graduate medical education payments for that resident, are about to be replaced by the United States Medical Licensing Examination (USMLE). Beginning June 1, 1992, foreign medical graduates will have the option of taking the USMLE or the FMGEMS. Effective July 1, 1993, only the USMLE will be administered, and foreign medical graduates must pass steps I and II in order to receive certification. Therefore, we proposed to revise § 413.86(h) to reflect this change in the examination requirements.

We received one comment supporting the proposed change, and we are adopting the change without revision in this final rule.

We note that section 1886(b) references only the FMGEMS. As stated in the proposed rule, we intend to seek a technical amendment so that the statute will provide explicitly for recognition of successor tests. We expect the Congress

to act on the technical amendment within one year.

VI. Changes to Capital Prospective Payment System Rules

In the June 4, 1992 proposed rule, we proposed to make a number of minor policy changes and clarifications in the capital prospective payment system rules. Several commenters indicated that in general the proposed changes were reasonable and did not comment on specific changes. The proposals and the specific comments that we received on them are discussed below.

A. Payments to New Hospitals (§§ 412.300, 412.302, 412.324, and 412.328)

The August 30, 1991 final rule implementing the capital prospective payment system established special payment provisions for new hospitals (56 FR 43418). Under § 412.324(b), a new hospital is paid 85 percent of its allowable Medicare capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period beginning at least 1 year after the hospital accepts its first patient is the hospital's base year for purposes of determining its hospital-specific rate. Beginning with the third year, the hospital is paid under the fully prospective or hold-harmless payment methodology, as appropriate. If the hospital is paid under the hold-harmless payment methodology, the hospital's hold-harmless payments for its old capital costs continue for up to 8 years.

As defined under § 412.300(b), a new hospital is one that has operated (under previous or present ownership) for less than 2 years and does not have a 12-month cost reporting period that ends on or before December 31, 1990. As stated in the June 4, 1992 proposed rule, we believe that the reasonable cost payment protection under the new hospital exemption should only be available to those hospitals that have not received reasonable cost payments in the past and need special protection during their initial period of operation. Therefore, we proposed to clarify that the new hospital exemption under the capital prospective payment system would not apply to a facility that opens as an acute care hospital if that hospital operated in the past under current or previous ownership and has a historic asset base.

Also, we proposed that a hospital that replaces its entire facility (with or without a change of ownership) would not qualify for a new hospital exemption. Although the hospital may experience a significant change in its asset base, we believe it would be

inappropriate to provide the hospital with special payment protection.

Therefore, we proposed to amend the definition of a new hospital at § 412.300(b) to clarify that the exemption applies only to hospitals that have been in operation for less than 2 years and does not apply to the following situations:

- A hospital that changes status from an excluded hospital paid under section 1886(b) of the Act to an acute care hospital subject to the provisions of section 1886(d) of the Act.
- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years.
- A hospital that closes and then reopens under either the same or different ownership.
- A hospital that builds a new or replacement facility at the same or a new location, even if a change in ownership or new leasing arrangements are involved.

Consistent with these changes, we proposed to revise § 412.328 to clarify that if a hospital (other than a new hospital) does not have a 12-month cost reporting period ending on or before December 31, 1990 as an acute care hospital, its hospital-specific rate would be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period (or a combination of cost reporting periods covering at least 12-months) ending after December 31, 1990.

We also proposed to clarify the old capital definition applicable to hospitals that qualify for a new hospital exemption. Under § 412.328(a)(2), a new hospital's base period is its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient. Although the preamble of the August 30, 1991 final rule (56 FR 43418) stated our intent to treat the hospital's base year costs as old capital costs, the regulations did not explicitly contain this provision. We proposed to revise § 412.302 to define a new hospital's old capital costs as its allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of its base period cost reporting period. The limitations in § 412.302(b) that apply to old capital costs would also apply to a new hospital except that the limitations would be based on the hospital's old capital costs for assets that were put in use as of the later of

December 31, 1990 or the last day of its base period cost reporting period.

After evaluating the comment discussed below, we are adopting the proposed changes in the new hospital capital payment provisions with one addition. In this final rule, we are clarifying that if a hospital has such low Medicare utilization in its original base period that it is not required to file a cost report, its hospital-specific rate will be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period for which a cost report is filed.

Comment: One commenter expressed concern that the proposed clarification of the new hospital definition at § 412.300(b) is too broad in scope and would prohibit many newly operating facilities from obtaining the new hospital exemption. The commenter indicated that restrictions on what would constitute a new hospital are premature based on limited program experience to date under the capital prospective payment system and suggested that if restrictions are necessary, HCFA should revise the new hospital definition to allow case-by-case determinations of whether a replacement facility qualifies as a new hospital. The commenter recommended that the determination be based on considerations such as the distance between the facilities and changes in the patient population, the medical staff, and patient care services.

Response: We believe that it is appropriate to proceed expeditiously to clarify the new hospital definition so that hospitals that are planning to replace their existing plant will know in advance how the replacement facility will be treated under the capital prospective payment system. It is particularly important to do so because the new hospital definition under the capital prospective payment system is not identical to the definitions used in other areas of the Medicare program, such as the new hospital definition for purposes of determining if a new provider agreement is needed or for purposes of determining eligibility for a new hospital exemption to the rate-of-increase limits applicable to hospitals that are excluded from the prospective payment system. Thus, we need to clarify the new hospital definition for capital prospective payment purposes to eliminate any confusion on this point.

Further, we believe it is appropriate to restrict the new hospital exemption under the capital prospective payment system to new entrants into the hospital field that do not have a historic asset base. As we pointed out in the preamble of the June 4, 1992 proposed rule (57 FR

23649), it would be inappropriate to provide special payment protection to a hospital simply because the hospital experiences a significant increase in its asset base. If we were to allow new facilities built by existing hospitals to qualify for the new hospital exemption, we would provide an inappropriate incentive for a hospital to replace existing plant instead of renovating or expanding its current facility. If the capital prospective payment system is to be effective in encouraging prudent capital spending, payment policies must be neutral with respect to decisions concerning whether to renovate or replace existing assets. Consistent with the need to provide neutral incentives, the proposed changes in the new hospital definition clarify that existing hospitals that move, realign, or replace the physical assets from which they operate will not qualify as a new hospital regardless of the mode through which such capital changes are effected.

In our view, criteria related to operational aspects of a hospital, such as those suggested by the commenter, should not apply to a determination affecting capital payments. A hospital could undergo the operational changes with little or no change in its asset base. Regardless of whether new patient care services, staff, patient demographics or other operational factors are involved or even form the basis for a substantial change in hospital assets, the determining factor in deciding whether a hospital is new for purposes of making capital payments should be directly related to a hospital's assets rather than its operations. Further, operational criteria would require a comparison of the hospital's operations before and after the replacement facility is opened; if such criteria were used in determining eligibility for the new hospital exemption, a hospital would not know with certainty at the planning stage for a replacement facility how the new assets would be treated under the capital prospective payment system. This uncertainty would not be desirable given the magnitude of the capital expenditure.

B. Portion of Hospital Assets Put in Patient Care Service after December 31, 1990 (§ 412.302)

In the June 4, 1992 proposed rule, we proposed to establish a general principle to follow in situations where nonreimbursable cost centers in the base year subsequently become allowable cost centers (57 FR 23650). Specifically, we proposed to revise § 412.302(b) to address situations in which a hospital may have a nonreimbursable cost center or

otherwise incur unallowable hospital costs for a depreciable asset as of December 31, 1990. Examples of these non-reimbursable costs include costs attributable to space or equipment that is leased to another party or used to provide non-hospital services in part of a building or department that is also used to provide acute care inpatient hospital services. To the extent the costs of such space or equipment become allowable inpatient hospital capital-related costs after December 31, 1990, we proposed that those costs would be recognized as old capital costs as long as a portion of the asset was in use for hospital inpatient care as of December 31, 1990. The allowable costs that could be recognized as old capital costs would be subject to the current provisions at § 412.302(b). If no portion of an asset was used to provide hospital inpatient care as of December 31, 1990, any allowable hospital inpatient capital-related costs of the asset would be recognized as new capital costs when the asset was returned to hospital inpatient care service. After consideration of the comment discussed below, we are adopting the proposed rule with a revision to clarify that only those costs that would otherwise qualify as old capital will be recognized as old capital costs if the non-reimbursable cost center is put in use for patient care.

Comment: One commenter requested that a building's "shelled in space" should be cited as an example of old capital cost and that costs associated with bringing such space into inpatient care use should be classified as old capital.

Response: We assume that by the term "shelled-in space" the commenter means partially completed construction that has never been put in use for patient care. If the "shelled-in space" was part of an asset that was used to provide hospital patient care as of December 31, 1990 (for example, a partially constructed floor of a building with other floors that are in use for patient care), the costs for the "shelled-in space" as of December 31, 1990 that otherwise meet the criteria for recognition of old capital would qualify as old capital costs when it is put into use for patient care. However, additional costs that are incurred after December 31, 1990 to bring the asset into patient care use would be classified as new capital because the hospital was not obligated to incur those costs as of December 31, 1990. If the "shelled-in space" is not part of an asset that was in hospital patient care use as of December 31, 1990 (for example, if the "shelled-in space" is a separate building), it would

not qualify as old capital. We do not believe it is necessary to identify specific types of costs that would be recognized under the proposed change. However, we are revising the proposed change to clarify that the costs for the non-reimbursable cost center will be recognized as old capital when it is put in use only to the extent the remaining criteria for recognition of old capital are also met.

C. Treatment of Old Capital Costs When Hospitals Are Leased After December 31, 1990 (§ 412.302(b))

The August 30, 1991 final rule addressed how various situations involving changes of ownership and sale-and-leaseback transactions are treated under the capital prospective payment system (56 FR 43395 and 43405). In the June 4, 1992 proposed rule, we proposed a clarification of our policy in this area (57 FR 23650).

We proposed to revise § 412.302(b) to allow continued recognition of the base period old capital cost determinations in situations where a hospital is leased without assumption of the hospital's asset costs. However, we proposed to limit the amount of allowable capital-related costs that could be recognized as old capital to the amount that could be recognized for the same assets in the last cost reporting period before the current lease became effective. Any lease costs above that limitation would be paid for as new capital cost. Without the proposed change, all lease costs would have been recognized as new capital since there was no lease obligation as of December 31, 1990. The proposed policy would affect only those hospitals eligible for capital prospective payments on the basis of the hold-harmless methodology.

As noted in the June 4, 1992 proposed rule, for purposes of determining old capital costs, treatment of lease costs that involve leasing of portions of a hospital's operation or assets would continue to be subject to the provisions of §§ 412.302(b)(3) and (c)(1)(vi).

No comments were received on the proposed change and we are adopting it without revision in this final rule.

D. Obligated Capital Costs (§ 412.302(c))

We received one comment associated with the general requirement for obligated capital that was not directly related to any of the proposed changes discussed below.

Comment: Obligated capital costs for moveable equipment is recognized under the regulations if there was a binding contractual agreement that was executed before December 31, 1990. The comment suggests that HCFA clarify

that the definition of legally obligated capital includes purchase orders that are issued by hospitals.

Response: As we stated in the preamble to the final regulations implementing the capital prospective payment system (56 FR 43392), in most cases the determination of the existence of a binding enforceable agreement will be a relatively straightforward matter that can be made by the intermediary based on the documentation submitted by the hospital. To address issues concerning whether particular documents establish a binding agreement and create an enforceable obligation under State law, we are establishing an internal process for legal review of such evidence. We provided for this approach because we are aware, based on previous program experience, that we must look to State law when there is no controlling federal statute on a matter. This approach is particularly applicable in cases where the issue arises of whether a purchase order represents a binding agreement under State law in light of the fact that most States have adopted the Uniform Commercial Code with little or no change and the code provides that an order may represent an invitation to contract for goods and not an absolute obligation in many cases. Since the obligated capital regulation requires that a contract between two unrelated parties must be formed no later than December 31, 1990, the requirements of that provision clearly may not be met unless the supplier of the goods or services indicates acceptance (i.e., delivery, invoice, receipt of payment, etc.) or is required to perform by the regulatory deadline under State law even in the absence of evidence of acceptance. When this evidence is not submitted, we do not believe that we can recognize the purchase order alone as unquestionable evidence of a binding contract under any State's law. When there is an issue of acceptance of a purchase order, or automatic requirement for performance due to the simple issuance of a purchase order under State law, we will employ the internal legal review process referred to in the preamble to the final regulations for the capital prospective payment system. As a result we are retaining the current regulatory language regarding binding agreements at § 412.302(c)(1).

1. Deadline for Putting Assets in Use

Capital-related costs attributable to assets that are put in use after December 31, 1990 but for which the hospital was obligated as of December 31, 1990 may be recognized as old capital costs under certain conditions.

Under the general rule, one condition is that the asset be put in use for patient care before October 1, 1994. Under the rule relating to hospitals affected by a lengthy certificate-of-need process (§ 412.302(c)(2)), the asset must be put in use before the earlier of October 1, 1996 or 4 years from the date the certificate-of-need was approved. Under § 412.302(c)(1)(iv), if a hospital experiences delays due to extraordinary circumstances beyond its control, HCFA may extend the October 1, 1994 deadline for putting an asset in use to no later than September 30, 1996.

Current regulations do not establish a process for granting an extension in the October 1, 1994 deadline. Therefore, we proposed requiring that a hospital requesting an extension of the deadline must notify its intermediary of the extraordinary circumstances that delayed, or will delay, completion of the project beyond the original deadline. The request for an extension must be in writing and filed with the intermediary by the later of January 1, 1993 or 180 days after the event leading to the delay. The request must describe the circumstances contributing to the delay and explain why they are extraordinary and beyond the hospital's control. The request must also explain why the delay cannot be overcome and must provide a new estimated completion date established by the contractor, supplier, or other servicing party. The intermediary would review and verify the documentation submitted by the hospital. The intermediary would forward the request and the results of its review to HCFA within 60 days. Unless additional information is required, HCFA would notify the intermediary of its decision on the request within 90 days of receiving the request from the intermediary.

Based on public comments supporting the proposed change, we are adopting it in this final rule without revision.

Comment: A commenter requested that we describe the requirements and timeframe for a hospital to appeal a decision regarding an extension in the deadline for putting a project into patient care use.

Response: There is no separate appeals process for decisions regarding whether an extension in the deadline for completing a project is warranted by extraordinary circumstances. Instead, as provided in §§ 412.328(g)(2)(iii) and 412.344(d)(2), the final determinations for the hospital-specific rate and the hold-harmless payment affected by such decisions are subject to administrative and judicial review under Chapter 42, part 405, subpart R. Thus, if a hospital is

denied an extension in the deadline, the decision is not subject to formal appeal until the first cost reporting period affected by the decision, that is, the first cost reporting period during which the asset has been put in use and is classified as new capital. The intermediary's determination of capital payments for that cost reporting period is subject to the normal appeal procedures for intermediary cost report determinations. In the interim, if the hospital has additional information that would affect the determination, it may appeal the decision informally to HCFA through the intermediary.

2. Deadline for Notifying Intermediary of Obligated Capital

Section 412.302(c)(1)(v) provides that a hospital must notify its intermediary that it has obligated capital within 90 days of the date the hospital first becomes subject to the capital prospective payment system. The hospital's notification must include documentation establishing that the capital project meets the criteria for recognition as obligated capital and a description of the project and its estimated costs as of December 31, 1990. The intermediary determines whether the applicable criteria are met and notifies the hospital of its decision before the close of the hospital's first cost reporting period under the capital prospective payment system. The intermediary's determination is contingent on the asset being put in use for patient care by the applicable date.

To avoid disadvantaging hospitals that may not have understood the importance of making a timely submission to the intermediary, we proposed revising § 412.302(c)(1)(v) to extend the deadline for submission of obligated capital cost documentation. We proposed that a hospital must notify its intermediary of any obligated capital by the later of October 1, 1992 or 90 calendar days after the hospital becomes subject to the capital prospective payment system.

Consistent with the extension of the notification deadline for the hospital, we also proposed to extend the deadline for the intermediary's notification to the hospital of its obligated capital determination. We proposed that the intermediary would have 1 year from the date the hospital submits its complete documentation to advise the hospital of the intermediary's decision. Based on further consideration, we are revising the proposed changes to require that the intermediary notify the hospital of its determination by the later of the end of the hospital's first cost reporting period under the capital prospective

payment system or 9 months from the date the hospital submits its complete documentation.

Comment: Several commenters specifically indicated that the proposed change was reasonable. Noting that hospitals are at different stages of complying with the notification requirement based on when they became subject to the capital prospective payment system, one commenter recommended that the date for notifying the intermediary of obligated capital be extended to 90 days after the publication of this final rule.

Response: We believe that the proposed change represents a reasonable deadline for all affected hospitals. In general, we believe that 90 days after a hospital becomes subject to the capital prospective payment system is sufficient time for a hospital to notify its intermediary of obligated capital. Since hospitals with cost reporting periods beginning in late FY 1992 have had more advance warning on the notification requirements and their implications than hospitals with cost reporting periods beginning in early FY 1992, an extension in the deadline is unnecessary for these hospitals. Moreover, an additional 90 day extension would limit the amount of information on obligated capital that we would have available in developing the proposed rule for FY 1994 capital payment policies and rates. As complete information as possible is needed not only to refine the capital acquisition model used for budget neutrality purposes but also to monitor the impact of the capital prospective payment system and determine if any policy changes would be appropriate. Based on these considerations, we are extending the notification deadline in this final rule as proposed.

After further consideration, we are also shortening the deadline for the intermediary's determination. The current rules provide that the intermediary will have until the end of the hospital's first cost reporting period under the capital prospective payment system, or 9 months if the hospital notified the intermediary on the 90 day deadline. In the June 4, 1992 proposed rule, we proposed to allow the intermediary one year to make its determination. In view of both the hospital's and HCFA's need to know the obligated capital determination as soon as possible, we are revising the intermediary's deadline to the later of the end of the hospital's first cost reporting period under the capital prospective payment system or 9 months from the date the hospital submits its

complete documentation on obligated capital to the intermediary.

3. Certificate-of-Need Approvals

Under § 412.302(c)(2), a capital project that is affected by a lengthy certificate-of-need (CON) approval process may qualify as old capital if certain conditions are met. One of the conditions is that the hospital filed the initial CON application on or before December 31, 1989 and had not received approval as of September 30, 1990. If the hospital received approval no later than September 30, 1990, we believe it is reasonable for the hospital to have entered into a contractual obligation for the project on or before December 31, 1990, in which case the project will qualify under the general rule for obligated capital. However, as discussed in the June 4, 1992 proposed rule, some states grant CON approvals that are conditional upon the hospital fulfilling certain requirements (57 FR 23652).

Because the August 30, 1991 final rule did not address conditional approvals, we proposed amending § 412.302(c)(2)(i)(B) to provide that if a hospital received conditional CON approval for a project, the intermediary will assess the nature of the conditions and determine whether the hospital received sufficient approval for the project to proceed without undue delay. We believe that the intermediary could best ascertain whether such conditions were sufficient in themselves, given the specific circumstances, to prevent a hospital from proceeding with the project without delay. As is the case with other obligated capital determinations, there would be an internal review process for the intermediary to obtain guidance on questionable cases.

We received several comments that were supportive of the proposed change and we are adopting it without revision in this final rule. As discussed below, we received other comments on the provisions relating to obligated capital for hospitals subject to a lengthy certificate-of-need process that were not directly related to the proposed change.

Comment: We received several comments from individual hospitals and associations requesting revision to the provisions related to obligated capital costs for hospitals subject to a lengthy certificate-of-need (CON) process. Citing problems and delays frequently encountered throughout the process, such as a requirement for separate CON approvals for each phase of a multi-phase project that are contingent on completion of earlier phases, the

commenters suggested that the policies be revised to:

- Allow later phases of a staged construction project to be deemed part of the originally approved obligation for purposes of meeting the December 31, 1989 deadline.
- Extend the deadline for putting the project into patient care use by up to 3 years.
- Allow a 10-year transition for each phase under the hold-harmless methodology.

We also received comments suggesting that the expenditure threshold for recognition of obligated capital was too stringent for small hospitals. Some of the commenters suggested that we lower the initial expenditure threshold to the lowest of \$750,000, 10 percent of the estimated cost or 1 percent of inpatient operating cost (excluding capital costs), and extend the deadline for incurring the expenditures from December 31, 1990 to December 31, 1991.

Response: In developing the capital prospective payment policies set forth in the August 30, 1991 final rule, we were aware that some hospitals would be undertaking major capital projects during the transition from reasonable cost-based payments to prospective payments based solely on the Federal rate. We are monitoring the implementation of the capital prospective payment system closely. As we obtain additional information on those hospitals undertaking major projects that have been delayed by the CON process but do not qualify as obligated capital, we will reassess our transition payment policies. However, any reassessment will be made within the policy framework used to establish the initial transition payment policies.

In establishing the special provision for hospitals that are subject to a lengthy CON process, we recognized that such hospitals should not be disadvantaged if they reasonably anticipated the CON approval process in their capital planning but were unable to meet the December 31, 1990 cut-off date for obligated capital because timely CON approval was not received. Our intent was not to afford more favorable treatment for these hospitals than for other hospitals, but rather to make a reasonable and equitable allowance for the impact a lengthy CON process may have on the hospital's ability to meet the criteria for recognition of obligated capital costs as old capital in order to not disadvantage those hospitals that had already made a substantial financial commitment. Thus, the intent was to put these hospitals on a comparable footing with other hospitals.

We believe that it would be premature to make modifications in the CON provision at this time. We are sympathetic to the difficulties faced by some hospitals subject to a lengthy CON process. However, we believe that any modifications should be made only after we have sufficient information about the extent of potential problems unique to hospitals subject to the lengthy CON process as well as other hospitals that, for example, may meet all requirements for obligated capital other than the deadline for putting the project in use for patient care or have multi-phase projects, only the first stages of which will qualify as obligated capital. We wish to avoid ad hoc policy changes that might appear appropriate based on the specific circumstances of a few hospitals but which are not appropriate when the situations of other hospitals are also taken into account. Since the first three changes suggested by the commenters would not affect actual program payments until the capital projects are completed later in the transition, we believe it is not necessary to give them additional consideration before we complete a preliminary evaluation of how the capital prospective payment transition rules affect hospitals that are initiating major capital projects that do not meet the obligated capital requirements. To facilitate a systematic evaluation of this issue before next Spring, we welcome information from hospitals that are in this situation but have not already advised us of their circumstances. If we conclude that changes in our transition payment policies would be appropriate, we would include them in the proposed rule setting forth our FY 1994 capital payment policies and rates.

With regard to the recommendations by the commenters on the CON expenditure threshold, we note that we established the CON provision to protect hospitals with major capital projects that had made a significant financial commitment as of December 31, 1990 (the cut-off date for obligated capital), but would not be able to meet the obligated capital provision because of a lengthy CON process (56 FR 43393). If the hospital had not made a substantial financial investment, there is no indication that it was fully committed to proceeding with a project regardless of the capital prospective payment system nor would the hospital suffer financial loss if it decided not to proceed with the project. In the August 30, 1991 final rule, we established the threshold, based on comments received to the proposed rule, at the lesser of \$750,000 or 10 percent of the estimated project cost, to ensure that it would be

proportionate to the size of the project without being unreasonably high for large projects. We believe that the threshold is a reasonable standard to identify whether a substantial financial commitment had been made on a major capital project. Also, we believe it is appropriate to require that the commitment be made as of the same deadline for legally obligated capital. To provide otherwise would be to give hospitals subject to a lengthy CON process more favorable treatment than that afforded other hospitals. Based on the foregoing considerations, we are retaining the current expenditure thresholds.

E. Adjusting the Hospital-Specific Rate—Transfer-Adjusted Discharge and Case Mix Index for Subsequent Base Periods (§§ 412.328(b)(3) and (c)(1))

Sections 412.328(b)(3) and (c) provide for transfer adjustment factors to the discharge count and case-mix index used to calculate each hospital's hospital-specific rate. (See 57 FR 23652 for details.)

In the August 30, 1991 final rule, we provided for only the transfer adjustment factors for the initial base year period. In the June 4, 1992 proposed rule, we proposed to amend §§ 412.328(b)(3) and 412.328(c) to apply appropriately updated transfer adjustment factors for later cost reporting periods that may be used as a base period in the case of a new hospital or a hospital-specific rate redetermination. For later base periods beginning before October 1, 1991, we proposed to determine the discharge transfer adjustment factor for a hospital using the applicable base period MEDPAR data on file as of the December 31 or June 30 update occurring at least 6 months after the close of the base period involved. Thus, for cost reporting periods ending on or before June 30, 1991, the transfer-adjusted case mix index and discharge transfer adjustment factors provided in Table 9 of the June 4, 1992 proposed rule would be considered final values. We stated that we would publish values for cost reporting periods ending after June 30, 1991 through December 31, 1991 in this final rule. We proposed that for subsequent periods beginning on or after October 1, 1991, the intermediary for the hospital would determine the discharge transfer adjustment factor for a base period using the most recent billing data available from the Provider Statistical and Reimbursement System as of the date of the final determination of the hospital-specific rate. The transfer-adjusted case-mix index would be

determined by using the same data that is used to determine the discharge transfer adjustment factor.

Since no specific comments were received on the proposed change, we are making the change as proposed in this final rule. The transfer adjustment factors for cost reporting periods ending after June 30, 1991 through December 31, 1991 are in Table 9 of this Federal Register document.

F. Redetermination of the Hospital-Specific Rate (§ 412.328(f))

Section 412.328(f) provides that upon request by a hospital paid under the fully prospective payment methodology, the intermediary redetermines the hospital-specific rate to reflect changes in old capital costs as determined in a cost reporting period beginning subsequent to the base period but no later than the hospital's cost reporting period beginning in FY 1994 (or the cost reporting period beginning after obligated capital that is recognized as old capital is put in use, if later).

We proposed to amend § 412.328(f)(1)(i) to clarify that a redetermination is permitted only when there is an increase in the hospital's total old capital costs. We proposed to state explicitly that no redetermination would be made to recognize other conditions that could affect the hospital-specific rate, such as a decline in utilization that produced an increase in the hospital's old capital cost per discharge.

Also, current regulations provide that a request for redetermination must be made within 90 days of the close of the affected cost reporting period, when the cost report is ordinarily due. We proposed to amend § 412.328(f)(1)(iii) to extend the deadline to coincide with the cost report due date and any extension in the cost report filing date granted by the intermediary.

Last, we wish to avoid unnecessary requests, that is, situations where the redetermined hospital-specific rate would be lower than the hospital's current rate. As a result, we proposed revising § 412.328(f)(1)(iii) to require that a hospital requesting a redetermination must submit, along with the cost report for the period it is requesting as its new base year, an estimate indicating that its new hospital-specific rate would be higher than its current rate. However, since at the time a redetermination is requested the hospital's current old capital costs have not been audited and the Medicare statistical data is subject to change, we also proposed to amend § 412.328(f)(3) to provide that if the intermediary determines after audit that the new hospital-specific rate is lower,

the hospital would be allowed to withdraw its request within 60 days of the intermediary's notification to the hospital of the redetermined rate.

After consideration of the comments discussed below, we are modifying one proposed change. In this final rule, we are providing that if a redetermined hospital-specific rate is lower than the hospital's current hospital-specific rate, the intermediary will deny the hospital's request instead of providing the hospital with an opportunity to withdraw the request.

Comment: Several commenters disagreed with our clarification that only an actual increase in total old capital costs will be recognized as a basis for a redetermination of the hospital-specific rate and that a change in utilization would not be recognized. One commenter argued that other events, such as loss of physician staff, have a critical impact on a hospital's capital costs per case, especially for small rural hospitals. The commenter noted that since capital costs are fixed, they cannot be reduced as readily as operating costs in response to lower utilization. Another commenter requested clarification regarding how a utilization change would be taken into account when the hospital-specific rate is recalculated based on an increase in total old capital costs. Finally, a commenter noted that if the hospital's discharges in the new base period were used in redetermining the hospital-specific rate, hospitals with an increase in total old capital costs but reduced utilization would have an advantage over hospitals with no increase in total old capital costs but reduced utilization. The commenter suggested that no adjustment be made for any utilization change when the hospital-specific rate is redetermined; instead, the hospital-specific rate should be adjusted by the percentage increase in old capital costs.

Response: As we pointed out in the preamble of the June 4, 1992 proposed rule (57 FR 23653), the proposed limitation on hospital-specific rate redeterminations is not a change from our original policy but a necessary clarification because of confusion over the original language of the regulation (56 FR 43454). We further explained that the redetermination provision was incorporated into the final rule in order to provide for recognition of obligated capital costs comparable with the provision for hospitals paid under the hold-harmless payment methodology. There was no intention to provide protection from utilization declines through the hospital-specific rate redetermination policy. We reiterate that one of the primary purposes for

moving to a per discharge payment was to enable the Medicare program to provide incentives for efficiency by ending subsidies for under-utilized capacity. We believe that to expand the basis for redetermination to utilization changes, regardless of the cause or the fact that capital-related costs are more difficult for providers to control, would undermine the balance we have obtained with this policy. We believe that the minimum payment levels that we have established through the exceptions policy are adequate protection for hospitals that suffer a drop in utilization or other adverse conditions that are often experienced in the normal course of hospital operations. We do not find the rationale presented by the commenters to be a sufficient basis to revise our original policy intent in this matter.

Once a hospital qualifies for a hospital-specific rate redetermination based on an increase in total old capital costs, the hospital-specific rate will be redetermined based on the hospital's Medicare old capital costs and discharges in the new base period. As one commenter pointed out, using the discharges in the new base year could in some cases give the hospital that experiences a decline in utilization an advantage over hospitals with declining utilization that do not qualify for a redetermination. Although this may occur in some cases, we would expect that most hospitals with significant obligated capital will experience an increase in utilization when the project is completed and put in use for patient care. If we were to simply adjust the hospital-specific rate by the percentage increase in total old capital costs, we would not be accounting for the increased utilization or any change in Medicare's share of old capital costs resulting from the obligated capital. Since payment is on a per discharge basis, the Medicare program would in effect be paying the hospital twice for the increased costs attributable to utilization increases: Once through the higher hospital-specific rate and again through the increased number of admissions. Therefore, we are not adopting the commenter's recommendation.

Comment: Instead of notifying a hospital that a redetermination request would result in a lower hospital-specific rate and allowing 60 days for the hospital to withdraw its request, one commenter suggested that the intermediary should reject the request for redetermination.

Response: Our intent in requiring the hospital to withdraw its request was to

make the hospital an active and responsible participant in the redetermination process and to avoid unnecessary requests. As pointed out in the preamble to the June 4, 1990 proposed change (57 FR 23653), the hospital must recognize the significance of requesting a redetermination for increased old capital costs. However, upon further consideration, we believe that the requirement that the hospital demonstrate an increase in its hospital-specific rate is sufficient to reduce the incidence of unwarranted requests. To avoid establishing an unnecessary administrative burden, we are adopting the commenter's suggestion in this final rule.

Comment: One commenter requested that the deadline for requesting a hospital-specific rate redetermination be set at 120 days from the end of the cost reporting period to allow a hospital time to analyze its capital costs.

Response: We believe that the proposed change will allow a hospital adequate time to analyze its costs and provide the necessary documentation for a hospital-specific rate redetermination at the same time the cost report is due. Since the revised cost reports will provide for separate reporting of old capital costs, the hospital will be able to compare its old capital costs per discharge for the cost reporting period with those for the original base year. Moreover, since the redetermination request is in part a request for a retroactive change in the basis for the capital payment determination for the cost reporting period, it is most appropriately filed as part of the cost report submission. This will allow the intermediary to take the request into consideration during tentative settlement and avoid in many cases the administrative burden of an additional retroactive adjustment prior to final settlement of the cost report. Since the hospital-specific rate redetermination and the cost report settlement process are so closely linked, we are adopting the proposed change without revision in this final rule.

Comment: One commenter stated that HCFA has not addressed when retroactive and prospective payments would be made to a hospital reflecting the redetermined hospital-specific rate and suggested that provision be made for interim payment adjustments so that hospitals will not have to wait a significant length of time before receiving the additional payments. The commenter also indicated that no deadlines are set for responses to hospital requests for a hospital-specific rate redetermination.

Response: Payments to providers, including interim payments, are addressed comprehensively in regulations at part 413, subpart E. These rules provide intermediaries with adequate flexibility to adjust payments on the basis of appropriately documented changes in capital costs during a cost reporting period. We believe they are as appropriate for capital payment purposes as they are for all other hospital payment provisions.

Based on an initial redetermination of the hospital-specific rate, the intermediary has discretionary authority to make a retroactive adjustment in the tentative settlement for any closed cost reporting periods affected by the redetermined hospital-specific rate. In addition, the intermediary may adjust the interim payments for a current cost reporting period to take into account the initial redetermined hospital-specific rate. The intermediary's decision to make these payment adjustments will be based on its assessment of the accuracy and adequacy of the documentation supporting the redetermination request. The final redetermination of the hospital-specific rate cannot be made until there has been a final settlement of the new base period cost report and the transfer-adjusted discharge and case-mix data needed to compute the rate are available. Since redetermination requests may be filed at different stages of the cost report cycle, a standard deadline for intermediary adjudication of a redetermination request and the resulting payment adjustments cannot be established. However, full retroactive application of the redetermined hospital-specific rate to the beginning of the new base period is clearly protected by § 412.336(c).

G. Effect of Hospital Mergers, Consolidations or Dissolution on the Hospital-Specific Rate (§ 412.331)

In the preamble to the August 30, 1991 final rule, we discussed the appropriate method to determine capital prospective payments when multiple hospitals merge or consolidate during the transition period (56 FR 43405). However, the guidelines set forth in that discussion were not incorporated into the regulations. Also, we did not address situations where a hospital would separate into two or more hospitals after the base period.

Therefore, we proposed to add § 412.331 to incorporate the guidelines provided in the preamble to the final rule of August 30, 1991 for mergers or consolidations that meet the criteria under § 413.134(k) and to establish rules for dealing with situations where a hospital separates into two or more

hospitals. We also proposed that if hospitals merge or consolidate into one hospital after the base year but during the transition period, the hospitals' latest 12-month or longer cost reporting periods ending on or before December 31, 1990 would be combined to determine a discharge-weighted average hospital-specific rate.

In addition, we proposed to clarify that the recalculation of the hospital-specific rate would be applicable only to those cases that meet the previously existing reasonable cost reimbursement rules regarding the criteria for recognizing a merger or consolidation for Medicare program purposes under § 413.134(k). In cases in which the merger or consolidation rules are not met, the transaction involved would simply be treated as a normal asset acquisition for Medicare program purposes.

We also proposed that if after the base year, a multi-campus hospital splits into two or more separate hospitals that are subject to the capital prospective payment system, the intermediary would determine if the base year capital-related costs and other statistical data for each of the resulting hospitals can be reconstructed from the original hospital's financial and other records. If that data can be determined, the hospital-specific rate for each of the resulting hospitals would be recomputed for the original base year under the current rules. If reconstruction of the necessary data is not feasible, each hospital's hospital-specific rate would be recalculated by establishing the respective hospital's base year as its first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) subsequent to the dissolution.

In determining each hospital's old capital costs, the amount that would be recognized as old capital would be limited to the capital-related costs attributable to assets that were in patient care use as of December 31, 1990, and the hospitals will be subject to all other transition period rules. The interim payments for such hospitals would be determined by the intermediary on the basis of the best data available prior to receipt of the new base period cost reports. The final hospital-specific rates would be applied retroactively to the later of the hospitals' first cost reporting period under the capital prospective payment system or the effective date of the dissolution in accordance with § 412.336(c)(2).

Comment: One commenter suggested that merged facilities should have the same opportunities to apply for

redetermination as other hospitals. In particular, the commenter noted that if the hospitals merged after the deadline for requesting a hospital-specific rate redetermination, they may be disadvantaged if one of the hospitals had been paid under the hold-harmless methodology and had not had a hospital-specific rate determination when obligated capital was put in use.

Response: The proposed change would not preclude a hospital that results from a merger of two or more previously independent hospitals from obtaining a redetermination of its old capital costs (as determined in the base year audits for the previously separate entities) if it is otherwise eligible for such a redetermination of the hospital-specific rate pursuant to the provisions at section 412.328(f). However, the commenter is correct that under current rules the resulting hospital would not qualify for a redetermination if the request is not filed timely. As a general rule, we do not believe that payment rules that are appropriately applied at the time should be reversed for subsequent events. At the same time, we can envision situations such as the one pointed out by the commenter where the result may be inequitable. We will examine the issue raised by the commenter and if we determine that any policy changes would be appropriate, we will propose them in a future rulemaking document.

Comment: A commenter questioned the preamble clarification that unless the asset acquisition meets the requirements stipulated for hospital merger or consolidation in the proposed § 412.331, those asset's costs would be treated as old or new capital under the rules provided at § 412.302 of the final capital prospective payment system regulations. The question arises because the writer understood that old capital costs always retain their identity as old capital.

Response: We provided discussion in the preamble of the June 4, 1990 proposed rule (57 FR 23653-23654) to call attention to the fact that old capital determinations are hospital-specific determinations and do not follow the asset if ownership of the asset is transferred to another hospital, except in the case of certain specified conditions. We believe that our descriptions of the limits on old capital have been adequate to alert hospitals that the purchase or sale of assets, even between facilities, will affect the treatment of the asset's costs unless a particular regulatory provision attaches to the type of transaction or asset involved.

If there is a change in the ownership of the hospital, the old capital determination made in the base year is retained by the hospital and its new owner(s). Similarly, we have extended this old capital protection to mergers and consolidations that are recognized under § 413.134(k). However, when Hospital A simply purchases the assets of Hospital B, even if it is the entire hospital (for example, when the latter hospital has filed for bankruptcy protection and its assets are being auctioned), those assets represent new capital assets to the purchaser (Hospital A) even if they were determined to be old capital assets when Hospital B was a participating Medicare provider. When there is no finding of merger or consolidation under Medicare program provisions, a simple asset acquisition is involved and the assets would be recognized as new capital costs if they were acquired after December 31, 1990 and no obligation to acquire them was in effect as of that date.

We believe these distinctions are necessary and appropriate so that no special incentives are created under the capital prospective payment system for hospitals to acquire assets that carry a potential advantage of being identified as old capital assets. We will make this distinction as clear as possible in our program instructions on the capital prospective payment system when those instructions are issued, as well.

Comment: One commenter asserted that HCFA should explicitly explain issues regarding change of ownership such as the limitations on recognition of old capital costs for new owners under the limits on valuation of assets when there is a change of ownership under section 1861(v)(1)(o) of the Social Security Act.

Response: The cost limitations on old capital assets when there is a change of ownership was addressed in the preamble to the August 30, 1991 final rule implementing the capital prospective payment system (56 FR 43405). Issues that arise from application of that limitation on an ongoing basis are addressed in program correspondence and will be included in program manual instructions that will be issued shortly.

H. Extraordinary Circumstances Exceptions Payments (§ 412.348(e))

Section 412.348(e) provides that a hospital may request an additional payment if the hospital incurs an unanticipated capital expenditure in excess of \$5 million (net of insurance proceeds) due to extraordinary circumstances beyond the hospital's control. A hospital must apply to the

HCFA Regional Office servicing its area within 180 days of the extraordinary circumstance causing the unexpected expenditures in order to qualify for exceptions payments. We proposed to amend the requirement in § 412.348(e)(2) to acknowledge the possibility that eligible events could occur prior to, or early in, the hospital's first cost reporting period under the capital prospective payment system. Consistent with our decision to extend the deadline for obligated capital notifications discussed above, we proposed changing the deadline for extraordinary circumstances applications to the later of October 1, 1992 or within 180 days of the occurrence of the extraordinary circumstances.

No comments were received on this proposal, and we are therefore adopting it without change in this final rule.

I. Special Payment Protections

1. Hospitals with High Medicare Usage

As discussed in detail in the June 4, 1992 proposed rule (57 FR 23654-23656), we believe it would not be appropriate to institute a payment adjustment or any special exceptions provisions for high Medicare utilization hospitals at this time. Our analyses found that the Medicare market shares for high Medicare utilization hospitals are not appreciably different from those of other prospective payment system hospitals. Their capital costs per case, and their total costs per case, are not higher than other hospitals, once we control for payment adjustments, occupancy, and the capital age and financing variables. Finally, there is no evidence that the older patients high utilization Medicare hospitals treat require more intensive resource use that would warrant a payment adjustment. As stated in the June 4, 1992 proposed rule, we will continue to monitor the characteristics of high Medicare hospitals, particularly once the data on their capital payment status is available.

Comment: One commenter believes that we did not adequately address several issues in our discussion of hospitals with high Medicare usage in the proposed rule (57 FR 23654). In particular, the commenter believes that we have not considered the role of seasonal population shifts in defining hospital market share, especially with regard to high Medicare utilization hospitals in Florida. The commenter also believes we should consider the extent to which the alternative sources of hospital care for Medicare beneficiaries are higher cost facilities or facilities that receive higher Medicare payments. In

addition, the commenter believes we should examine the extent to which care received at alternate hospitals relates to specialized services not available at the high Medicare facility. The commenter notes that we have not previously applied a market share test for other facilities which receive special payment protection. The commenter further notes that high Medicare hospitals have never claimed to have higher costs per case than other hospitals, but rather that they receive insufficient payments per case. Finally, the commenter is concerned that facilities with high Medicare usage show a lower increase in payments per case than other facilities in the impact analysis published in the proposed rule.

Response: In general, payment adjustments have two justifications: a classification that shows systematically higher Medicare costs of treating patients, such as the disproportionate share and indirect medical education adjustments, or a classification that raises systematic access concerns, such as sole community status and the special exceptions provisions for high disproportionate share hospitals under the capital prospective payment system. Since high Medicare hospitals do not have higher costs per case than other hospitals that treat Medicare beneficiaries, we turned to the market share information as a method of testing the importance of access issues with regard to high Medicare hospitals. With regard to the use of market share in determining the appropriateness of any payment adjustment for high Medicare hospitals, one method of qualifying for rural sole community hospital (SCH) status is to show that a hospital's market share meets various criteria. Urban SCHs must show that alternative sources of care are at least 35 miles away, which is evidence of limited access to care.

Our analysis indicated rural high Medicare hospitals that are not a SCH have a market share that is similar to other non-SCH rural hospitals. While it is true our analysis indicates that urban high Medicare facilities have higher market shares for medical discharges than their non-high Medicare counterparts, it is also true that a variety of alternative sources of patient care are available in their market area. According to research by Brigid Goody ("Medicare Dependent Hospitals: Who Depends on Whom?" Health Care Financing Review, forthcoming), on average more than four other hospitals currently serve the residents of the market areas of urban high Medicare

hospitals, and there are on average over 11 other hospitals within a 15 mile radius of a high Medicare hospital. This research shows that access is not a significant concern for Medicare patients of urban high Medicare hospitals.

The fact that payments to high Medicare hospitals are lower than payments to other hospitals does not lead to a conclusion that the high Medicare hospitals should receive a payment adjustment. High Medicare facilities treat less resource-intensive patients and are less likely to receive teaching and disproportionate share adjustments. As explained below in our response to ProPAC's comments regarding the level of the indirect teaching and disproportionate share adjustments, we believe that these adjustments are too high for operating payments, and that the lower adjustment levels set for capital PPS are appropriate for both capital and operating payments. However, we do not believe that the excessive operating teaching and disproportionate share adjustments to other hospitals support a payment adjustment for high Medicare hospitals that is not warranted by their costs.

It is unclear how seasonal migration could affect the market share analysis discussed in the proposed rule. The market share is defined as the share of Medicare discharges from all ZIP codes in a hospital's market area. The market area is defined as those ZIP codes, ranked in order of importance, that provide at least 75 percent of a hospital's discharges. It is extremely unlikely that a ZIP code from another State would contribute enough discharges to be included in a hospital's labor market area. In order for the effect of seasonal migrants to distort the market share analysis, seasonal migrants would have to have different hospitalization rates than residents. Moreover, a forthcoming article in Health Services Research by William Buczko ("Factors Affecting Interstate Use of Inpatient Care by Medicare Beneficiaries") demonstrates that the vast majority of interstate patient flow is due to beneficiaries seeking specialized care not available in their market area, rather than seasonal migration. In fact, 7.7 percent of admissions of Florida residents occur in other States (Buczko, page 303), while 9.1 percent of admissions occurring in Florida are residents of other States (Buczko, page 301), so the net migration effect is small.

Given that the standardized costs of

high Medicare hospitals are lower than non-high Medicare hospitals, and that there does not seem to be an access issue to alternative sources of care for the beneficiaries that use urban high Medicare facilities (those high Medicare hospitals with a significantly higher market share), we continue to believe that it would be inappropriate to establish any special payment protection for high Medicare hospitals at this time. We will continue to monitor their situation, however. In this regard, we note that the relatively lower average payment increases indicated in the impact analysis of this final rule for high Medicare hospitals is largely attributable to the elimination of the Medicare-dependent hospital provision effective for cost reporting periods ending after March 31, 1993.

2. Financially Distressed Hospitals that Serve Low Income Patients

As we noted in the proposed rule of June 4, 1992 (57 FR 23656), several organizations representing financially distressed hospitals that serve a large volume of low-income patients have expressed concern that their payments under the capital prospective payment system may be insufficient for the hospitals to obtain the necessary financing to undertake needed capital projects in the future. The organizations note that these hospitals do not have internal reserves that can be used to finance their capital projects and rely heavily on the Medicare and Medicaid programs for their revenues. If the funding from these sources is not adequate to cover the financing costs, the hospitals will not be able to complete the renovation and construction projects that are needed to preserve access to care for low-income populations.

In the proposed rule, we noted that organizations representing financially distressed hospitals had suggested a number of changes in the capital prospective payment system that were similar to suggestions made in the public comments that we considered in developing the August 30, 1991 final rule. We indicated that we believe it would be premature to modify the policies in that rule until we have had an opportunity to assess their impact.

Comment: Several commenters expressed general concern over the impact that the capital prospective payment system might be having on hospitals that do not have capital reserves and need to undertake major capital projects and stressed the need to monitor their situation closely. Specific

suggestions made by commenters included: payment adjustments for capital cycle and reliance on debt; special exceptions payments; and permanently maintaining the capital payment level at 80 percent of reasonable costs for high disproportionate hospitals and extending this provision for 10 years beyond the transition period.

Response: As we stressed in the proposed rule, we are concerned that financially distressed hospitals that provide needed services receive adequate payments under the capital prospective payment system. However, we believe that it is premature to modify the original policies after less than one year into the transition and before we have had an opportunity to assess the impact of those initial policies and evaluate whether they provide sufficient payment protections.

We note that we do not have evidence that indicates that the capital prospective payment system has had an immediate adverse impact on financially distressed hospitals that would warrant changes in our payment policies for FY 1993. To the extent a financially distressed hospital has recently completed or will be completing a major capital project within the year, the higher capital costs should be accounted for by the hold-harmless payment policies for old capital. Those with older plants and equipment should benefit from receiving a blend of their hospital-specific rate and Federal rate that is at or above their historical cost per case level. Moreover, the minimum payment level for urban disproportionate share hospitals with at least 100 beds will remain at 80 percent in FY 1993. The issue of adequate payments to financially distressed hospitals with new capital needs is closely related to issues involving hospitals that are undertaking major capital projects that do not qualify as obligated capital. In our earlier response to comments on the obligated capital policies, we noted that we will undertake a preliminary evaluation of how the capital prospective payment transition rules affect hospitals that are initiating major capital projects that do not meet the obligated capital requirements in time to consider policy changes beginning in FY 1994. In our evaluation, we intend to pay particular attention to financially distressed hospitals that serve low income patients. If we conclude that changes in our capital payment policies would be appropriate, we would include them in the proposed rule setting forth the FY 1994 capital payment policies

and rates. We may find, however, that the problems faced by these hospitals cannot be addressed through change in the Medicare capital prospective payment system, but that special legislation may be required to assure that these hospitals have access to needed capital.

We are also interested in the effect of the capital prospective payment system on rural areas. We solicit comments on whether there are unique capital problems of rural hospitals in meeting the needs of their Medicare populations, and, if so, how those problems might be addressed appropriately.

J. Minor Technical Corrections

We are making the following technical changes to the regulations:

- Section 412.113(a)(2)(E) will be corrected to note that sole community hospitals, as defined in § 412.92, are excluded from the capital payment reduction for periods prior to a hospital's cost reporting period beginning on or after October 1, 1991.
- Section 413.134(f)(2)(iii)(D) will be corrected to change the last reference for capital prospective payment system purposes to § 412.344(a)(2).
- Section 412.302(c)(1)(ii) will be revised to clarify that the qualifying criterion for obligation of moveable equipment is that a binding contract for lease or purchase of the equipment was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990.

In addition, we proposed a series of minor conforming changes throughout 42 CFR parts 412 and 413. These conforming changes are needed to ensure that our regulations specify which provisions apply to the prospective payment system for operating costs, which provisions apply to the prospective payment system for capital-related costs, and which provisions apply to both systems.

Comment: One comment was received requesting that HCFA clarify the obligated capital provision for moveable equipment due to its ambiguity in the final rule issued August 30, 1991 (56 FR 43450).

Response: We believe that the correction proposed to section 412.302(c)(1)(ii) (57 FR 23657) resolves the concern raised in this comment. We are, therefore, adopting the technical corrections made in the proposed rule without change in this final rule.

VII. Changes for Hospitals Excluded From the Prospective Payment System

A. Provisionally Excluded Hospitals and Units (§§ 412.22, 412.23, 412.25, 412.30, and 412.32)

1. Changes in the Status of Excluded Hospitals and Psychiatric and Rehabilitation Distinct-Part Hospital Units (§§ 412.22 and 412.25)

Since the inception of the prospective payment system for operating costs of hospital inpatient services in October 1983, certain types of specialty-care hospitals and hospital units have been excluded from that system under section 1886(d)(1)(B) of the Act. These currently include psychiatric and rehabilitation hospitals and distinct part units, children's hospitals, and long-term care hospitals. Section 6004(a)(1) of Public Law 101-239 amended section 1886(d)(1)(B) of the Act to provide that certain cancer hospitals are also excluded. The preamble to the January 3, 1984 final rule implementing the prospective payment system for operating costs (49 FR 235) stated that the status of a hospital or unit (that is, whether it is subject to, or excluded from, the prospective payment system) will be determined at the beginning of each cost reporting period. It also provided that changes in a hospital's or unit's status that result from meeting or failing to meet the criteria for exclusion will be implemented prospectively only at the start of a cost reporting period, that is, starting with the beginning date of the next cost reporting period (49 FR 243). However, this policy is not set forth in the regulations.

Current regulations at § 412.25(b) specify that changes in the bed size or square footage of an excluded unit may be made only at the start of the cost reporting period. However, that regulation does not specifically address cases in which an existing hospital changes the function of the unit, adds an entire new unit, or converts an existing excluded unit to an acute care unit paid under the prospective payment system. As a result, questions have arisen as to whether such changes could be recognized at times other than the start of a cost reporting period.

We proposed revising §§ 412.22 and 412.25 to specify that changes in the status of each hospital or hospital unit would be recognized only at the start of a cost reporting period. Except in the case of retroactive payment adjustments for excluded rehabilitation units described in § 412.30(c), any change in a hospital's or unit's compliance with the exclusion criteria that occurs after the

start of a cost reporting period would not be taken into account until the start of the following period. This policy would also apply to any unit that is added to a hospital during the hospital's cost reporting period.

We also proposed revising § 412.25(a) to specify that as a requirement for exclusion, a hospital unit must be fully equipped and staffed, and be capable of providing inpatient psychiatric or rehabilitation care, as of the first day of the first cost reporting period for which all other exclusion requirements are met. A unit that meets this requirement would be considered open regardless of whether there are any inpatients in the unit.

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: One commenter expressed support for the concept of making changes in the status of a hospital only for entire cost reporting periods. However, other commenters objected to this policy, stating that it unnecessarily penalizes hospitals for factors beyond their control, such as construction delays, that it discourages hospitals from making changes in their programs to meet community needs, or that it can place undue workload demands on regulatory agencies during certain time periods.

Response: We understand these commenters' concerns, and are particularly appreciative of the concern expressed regarding the workloads of regulatory agencies. However, we note that the current policies do not prohibit hospitals from making changes in their operations, nor do they result in denial of payment for the hospitals' services, since all the types of care furnished by hospitals that are excluded from the prospective payment system are also payable under the prospective payment system. We also believe that regulatory agencies, hospitals, and the public generally will benefit from policies that are clearly stated, can be easily understood by both hospitals and intermediaries, and can be simply administered. Recognizing changes in status only at the beginning of cost reporting periods is consistent with these goals, while recognizing changes in the middle of cost reporting periods would introduce added complexity to the administration of the exclusion provisions. Therefore, we are not revising the proposed changes based on these comments.

Comment: Several commenters objected to our concern that misallocations of cost could occur if changes in unit size or the opening of a new unit were recognized during cost

reporting periods. One commenter stated that cost reporting techniques such as the use of weighted averages or short-term interim cost reports are available and could be used to allow changes in facility size or status during a cost reporting period without causing a misallocation of cost. Another commenter suggested that Medicare cost reporting rules be revised to allow such changes to be recognized.

Response: We recognize that cost reporting techniques such as the use of weighted averages or the introduction of short-term interim cost reports could be used to identify the cost of changes in facility size or status during a cost reporting period. However, these proposed solutions would introduce significant added complexity to the administration of the exclusion provisions. This is particularly true if hospitals would make size changes more than once in a cost reporting period.

We are also concerned about the effect that allowing such midyear changes would have on making payment to excluded rehabilitation units. Hospitals with such units are now allowed to add new beds to those units at the start of a cost reporting period, based on a certification that the patient population treated in the beds will meet the 75 percent rule (see §§ 412.23(b)(2) and 412.30(b)). The added beds are provisionally excluded from the prospective payment system, and a retroactive adjustment is made if the rule is not actually complied with. If we were to allow hospitals to add beds during a cost reporting period as well, the compliance of those beds with the 75 percent rule would have to be assessed separately. Again, multiple changes within a year would further complicate this situation.

Because of these considerations, we continue to believe that changes in the bed size of an excluded unit or the establishment of new units should be recognized only at the beginning of a hospital's cost reporting period.

Comment: Several commenters approved of the proposal to consider a fully equipped and staffed unit to be open even if the unit has not yet provided any care to patients. However, the commenters recommended that the term "fully staffed" be interpreted relative to the initial expected usage of the new unit, not to the level of utilization that might be expected over the long term after the unit's start-up period.

Response: We recognize that hospitals do not always keep enough personnel on staff to function at 100 percent of their licensed capacity, but instead hire staff to meet expected demand and maintain

various contingency plans for calling in additional staff to deal with unexpected patient loads. Therefore, we agree that staffing levels should be realistic in relation to expected utilization. However, we do not believe any change in the regulations is needed to achieve this. We will clarify this point in instructions to individuals responsible for verifying compliance with the exclusion criteria.

Comment: One commenter stated that the term "fully equipped and staffed" could be subject to various interpretations, and recommended that we eliminate this test of whether a unit is open and instead allow a unit to be considered open if it admitted its first patient within 30 days of the start of its cost reporting period.

Response: We agree that some judgment will be required to determine whether a unit is fully equipped and staffed. However, the HCFA Regional Office staff responsible for implementing the exclusion provisions are also responsible for implementing Medicare health and safety requirements, and we believe they are well-suited to make these judgments. Moreover, the purpose of the judgment is not to decide whether the staffing levels are the best possible to deal with various patient loads, but to assure that a unit is actually a functional entity, rather than one which is set up to simulate compliance with the exclusion criteria and allow exclusion at the start of a particular cost reporting period, but is not capable of delivering patient care. We do not agree that the admission of at least one patient within 30 days would be a better indicator of whether a unit is actually functioning. The date of admission of the first patient may be beyond the hospital's control, and if no patient were admitted within the required time period, it would be necessary to reverse the exclusion of an otherwise qualified unit retroactively. Thus, we are not making the change recommended by this commenter.

2. Exclusion of New Rehabilitation Hospitals and Distinct-Part Rehabilitation Units with Initial Cost Reporting Periods of Less than 12 Months (§§ 412.23 and 412.30)

Under § 412.23(b)(8), a new rehabilitation hospital may be provisionally excluded from the prospective payment system for its first full 12-month cost reporting period of Medicare participation based on a written certification that the patients it intends to serve meet the criteria for patients needing rehabilitation services set forth in § 412.23(b)(2). The

regulations, however, do not address the case of a new hospital that begins operating at a time other than at the start of its regular 12-month cost reporting period. Similarly, our regulations at § 412.30 do not specify how a new rehabilitation unit that is a distinct part of a new hospital is to be treated when the hospital begins operating at a time other than at the start of its regular cost reporting period. New hospitals often begin operating at times other than the start of their regular cost reporting periods because of construction delays or other difficulties in starting a new facility. The cost reporting instructions in § 2414.1 of the Medicare Provider Reimbursement Manual allow a new hospital to select an initial cost period of not less than 1 month and not more than 13 months to cover the period between the actual start-up date and the beginning of the hospital's preferred 12-month cost reporting cycle.

To avoid requiring a new rehabilitation hospital to operate under the prospective payment system from the date it opens until the beginning of its first full 12-month cost reporting period, we proposed to revise § 412.23(b)(8) to permit provisional exclusion of the hospital for both the initial period it may elect under section 2414.1 of the Provider Reimbursement Manual and for the next full 12-month period. Under the proposal, the provisional exclusion would be effective for no more than two consecutive cost reporting periods with a combined total provisional exclusion period not to exceed 25 months.

Under the proposed policy, a separate retroactive adjustment would be made for each cost reporting period during which the hospital is provisionally excluded from the prospective payment system but does not meet the condition that at least 75 percent of the hospital's patients require intensive rehabilitative services (known as the 75-percent rule) set forth in § 412.23(b)(2). During the second cost reporting period of provisional exclusion, the hospital's compliance with the 75-percent rule will be assessed, and the status of the hospital for its third cost reporting period would depend on whether the hospital met the 75-percent requirement for its second cost reporting period.

We proposed to revise § 412.30(a) in order to provide similar treatment for rehabilitation units in hospitals that are newly participating in the Medicare program. Under this proposal, when a hospital begins participating in the Medicare program and concurrently opens a rehabilitation unit that meets

the applicable exclusion criteria, the unit would be provisionally excluded from the prospective payment system from the first day of the hospital's participation through the end of the second cost reporting period. Again, we proposed that the combined total provisional exclusion period not exceed 25 months. We also proposed revising the regulations to make it clear that a hospital that has undergone a change of ownership or leasing as defined in § 489.18 would be treated as a newly participating hospital for purposes of qualifying for the prospective payment system exclusion. However, the hospital itself would not be considered newly participating for purposes of exemption from the rate-of-increase limit because it has previously participated under the old ownership.

In this final rule, we are adopting the proposed changes as described above, with one revision. After further review of our proposal, we have concluded that provisional exclusion for the initial cost reporting period of a new rehabilitation hospital (or for the rehabilitation unit of a new hospital) that is other than 12 months in length should be no longer than 11 months, so that the total period of provisional exclusion for such a hospital or unit would be limited to 23 months, not to 25 months as we had proposed.

We are making this change in order to provide more uniform treatment of hospitals that begin at times other than the start of their regular 12-month cost report cycle relative to those whose opening coincides with the start of that cycle. As noted in the preamble to the June 4, 1992 proposed rule (57 FR 23658), current cost reporting instructions allow a new hospital to select an initial cost reporting period as short as 1 month, or as long as 13 months, to cover the period between the hospital's actual start-up date and the beginning of its preferred 12-month cost reporting cycle. If a hospital chooses an initial cost reporting period of 1 through 11 months, it will not have had a full 12-month cost reporting period of exclusion in which to show compliance with the 75 percent criterion. We therefore would allow it an additional 12-month period of provisional exclusion, in order to allow it the same qualifying period as a hospital that began operating at the start of its regular 12-month cost reporting period. However, a hospital that selects an initial cost reporting period of 13 months has a qualifying period that is longer than it would have had if it had started up at the beginning of its preferred 12-month cost reporting cycle, and there is no need to provide such a

hospital with an additional 12-month period of provisional exclusion. Therefore, we have revised these final regulations to provide, in §§ 412.23(b)(8) and 412.30(a)(3), that the total period of provisional exclusion for a new rehabilitation hospital or for the rehabilitation unit of a new hospital is the first full 12-month cost reporting period plus any initial short cost reporting period which is not less than 1 month and not more than 11 months in length.

Comment: One commenter expressed approval of the proposal to revise the regulations to specify that a hospital that has had a change of ownership as defined under § 489.18 may establish a rehabilitation unit and (assuming the unit is otherwise qualified) have that unit excluded from the prospective payment system as a new unit. The commenter asked whether this provision would apply only when the hospital has not previously operated a rehabilitation unit, and whether the change of ownership would trigger establishment of a new TEFRA base year.

Response: Under § 412.30, an exclusion for a new unit is available only to a hospital that has not previously sought exclusion for any rehabilitation unit. This provision would apply if the owner of the hospital following the change of ownership had not sought a rehabilitation unit exclusion for a unit of the hospital. The change of ownership would not in itself trigger a new TEFRA base year.

Comment: One commenter stated that the kind of provisional exclusion available to new rehabilitation hospitals and units should also be made available to new long-term care hospitals, since those hospitals also could be disadvantaged by being paid under the prospective payment system.

Response: We do not agree that provisional exclusion is appropriate for new long-term care hospitals, nor do we believe the law would support such a policy. The statute, at section 1886(d)(1)(B) of the Act, confers broad discretion on the Secretary in determining whether a hospital or hospital unit may be excluded on the basis that it furnishes rehabilitation services. In accordance with the authority, we permit such exclusions on the basis of written certifications. However, section 1886(d)(1)(B) sets forth specific criteria for a hospital to be excluded as a long-term care hospital; a hospital may be excluded as a long-term care hospital only if the hospital has an average inpatient length of stay of greater than 25 days. We do not believe that the statute permits us to extend the

exclusion for long-term care hospitals to a hospital which has not demonstrated actual compliance with the statutory requirement. We note that qualification as a rehabilitation hospital or unit depends on the characteristics of the patients and the types of services that the facility furnishes; such criteria can be assessed at a given point in time. In contrast, the criterion for exclusion as a long-term care hospital (average inpatient length of stay greater than 25 days) can be assessed only over a period of time. Thus, a hospital cannot qualify as a long-term care hospital until it has been in operation for some period of time. Therefore, we did not adopt this comment.

Comment: One commenter recommended that retroactive payment adjustments not be limited to provisionally excluded rehabilitation hospitals and units but also be available for hospitals or units that convert from one exclusion category to another, such as former psychiatric units that qualify for exclusion as rehabilitation units.

Response: The purpose of the retroactive payment adjustment for improperly excluded hospitals and units is to allow facilities that have been granted excluded status on a provisional basis to have their payments adjusted retroactively to reflect their actual functioning in situations where they expressed the intention of functioning as excluded facilities but did not actually do so. There is no provision that would allow us to adjust payments to a facility that actually converted from one type of hospital or unit to another, in order to reflect the amounts the facility might have been paid if the conversion had not occurred. For example, if a hospital stops functioning as a psychiatric hospital and reconfigures itself as a rehabilitation facility in an attempt to qualify for a prospective payment system exclusion as a rehabilitation hospital, but does not actually meet the 75 percent requirement, there would be no legal basis on which we could continue to pay the hospital as a psychiatric hospital, nor would there be any justification for doing so. Instead, the hospital would be paid under the prospective payment system. Thus, we did not adopt this recommendation.

3. Removal of Provisions for Excluded Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)

Existing regulations at §§ 412.23(c) and 412.32 apply to the exclusion of alcohol/drug hospitals and units. However, as reflected in § 412.32, the exclusion for alcohol/drug hospitals and units ended with cost reporting periods beginning on or after October 1, 1987.

Because this exclusion is no longer in effect, we are deleting §§ 412.23(c) and 412.32.

B. Definition of Discharge for Purposes of Applying the Rate-of-Increase Limit Applicable to Excluded Hospitals and Hospital Distinct Part Units (§ 413.40(c))

We proposed to revise the regulations to include a definition of "discharge" for purposes of applying the rate-of-increase limit applicable to hospitals and hospital distinct part units excluded from the prospective payment system. Section 412.4(a) defines a discharge for purposes of the prospective payment system as any of the following occurrences: The patient is formally released from the hospital; the patient dies in the hospital; or, the patient is transferred to a hospital or unit that is excluded from the prospective payment system. There is no definition of discharge specific to the rate-of-increase provision in § 413.40. However, our policy has been that the definition of § 412.4(a) should be followed in applying the rate-of-increase limit.

As explained in the June 4, 1992 proposed rule, we have found that in practice this policy is not followed in many situations involving exhaustion of Medicare benefits prior to discharge. We proposed to change our policy to conform to current practice. We proposed to revise § 413.40(c)(2) to indicate that a discharge would be defined as set forth in § 412.4(a), except when the beneficiary exhausts Medicare inpatient hospital benefits (including the election to use lifetime reserve days) during the inpatient stay. In that case, the patient would be considered discharged on the date that Medicare benefits are exhausted.

We received several comments concerning the proposed definition of discharge. Many commenters supported the proposed change. After consideration of those comments and the comments discussed below, we are establishing the definition of discharge as proposed.

Comment: One commenter believes that the proposed definition of discharge may affect the comparability between a hospital's current cost per discharge and the hospital's base year cost per discharge. A hospital's TEFRA target rate is based on its inpatient operating costs divided by the number of Medicare discharges in the hospital's base year. The commenter stated that a hospital should be allowed to elect to rebase due to the change in definition of discharge regardless of whether it has a material effect on its TEFRA target rate, because a hospital may not be able to

compute the effect due to the time that may have elapsed since its base year.

Response: We do not agree with the commenter. Even if a different discharge definition were used in the base period, we believe that there should be no distortion in the target amount. Although there may be situations in which benefits were exhausted in the base year but the patient was not counted as a discharge until a subsequent cost reporting period, it is just as likely that the base year cost report discharge count included patients who were discharged in that period but who exhausted benefits in an earlier cost reporting period. This is similar to the averaging that occurs with other discharges. That is, there are discharges early in the cost reporting period for which most costs were incurred in the previous cost reporting period and there are admissions later in the cost reporting period that will not be discharged until the subsequent cost reporting period. Therefore, there is no cause to adjust the target amount due to the new definition of discharge.

As we stated in the proposed rule, the revised discharge definition is necessary to conform the discharge count to current practice. Although the revised definition is effective with discharges (as defined in revised § 413.40(c)(2)) occurring on or after October 1, 1992, we do not intend to enforce the discharge definition in § 412.4 retroactively. Retroactive enforcement would require cost report reopenings because most Medicare cost reports have been settled based on the practice of counting a discharge when the patient exhausts benefits. If, contrary to common practice, the hospital's discharge count has been based on § 412.4 in prior cost reporting periods, the hospital should be advantaged by the revised discharge count. In this case, the first cost reporting period affected by the new policy (that is, the cost reporting period ending on or after October 1, 1992), the hospital's discharge count would include all patients that are discharged in that cost reporting period (and have not previously been counted as a discharge for that inpatient stay) and any patients who exhausted Medicare benefits in that or an earlier period but have not been discharged from the hospital. In no event will a patient be counted as a discharge more than once during an inpatient stay.

Comment: A commenter recommended that HCFA review its practice of establishing the count of discharges and establish in this final rule an approach to reconcile

differences in provider and intermediary discharge counts.

Response: The discharge count used by fiscal intermediaries in settling Medicare cost reports is derived from the PS&R. The PS&R is designed to capture all statistical and payment data through the claims processing system. Any differences between the hospital's records, which should reflect the same data as the claims to Medicare, should be easily reconciled to the data derived from the PS&R. Any discrepancies detected through an error in the PS&R will be corrected through modifications to the PS&R data in the same manner as other reconciliations are effected. Establishing a separate approach to reconcile the differences is not necessary since the PS&R is an interface system through the claims processing system and should tie into the hospital records.

C. New Hospital Exemption Applicable to Excluded Hospitals (§ 413.40 (e) and (f))

Excluded hospitals and units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost, subject to rate-of-increase limits. Under the rate-of-increase limits, an annual target amount (stated as the inpatient operating cost per discharge) is set for each hospital based on the hospital's own cost experience in its base year. This target amount, updated for inflation, is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

Under §§ 413.40 (e) and (f), a new hospital may be exempted from the rate-of-increase limit on its inpatient operating costs if the hospital files a request with its fiscal intermediary within 180 days of receiving the notice of program reimbursement for the hospital's second cost reporting period. (This would be the first cost reporting period for which a hospital is subject to the rate-of-increase limit on its inpatient operating costs). As specified under § 413.40(f)(1)(i), a new hospital is a provider of hospital inpatient services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. The new hospital exemption expires at the end of the first cost reporting period beginning at least 2 years after the date the hospital admits its first patient. The last cost reporting period for which the exemption is in effect is the base period for determining the target amount applicable to subsequent cost reporting periods.

We proposed making three changes to the provisions of § 413.40(f)(1)(i) concerning new hospital exemptions from the rate-of-increase limit. The first proposed change would make the new hospital exemption automatic rather than at the hospital's discretion. As discussed in the proposed rule (57 FR 23659), we believe that offering a hospital the choice of requesting or foregoing an exemption sometimes allowed new hospitals to obtain a competitive advantage over other hospitals. To remedy this situation, we proposed revising § 413.40(f)(1)(i) to apply the exemption automatically to all new hospitals rather than making the exemption contingent on a request from the hospital.

Also, under current policy, a hospital may be in operation for 3 or more years before it is subject to the rate-of-increase limit. We believe that a hospital's second year of operation should be sufficiently representative to be used to establish the target amount. Therefore, we proposed reducing the new provider exemption to 2 years. A new hospital would be exempt from the rate-of-increase limit through its cost reporting period ending at least 2 years after the hospital accepts its first patient. The base period would be the first 12-month cost reporting period that begins at least 1 year after the hospital accepts its first patient.

Our third proposed change in the new hospital exemption policy concerned the issue of whether a participating facility that reorganizes (for example, from an excluded hospital to an excluded unit of an acute care hospital) or changes the basis of its participation in the Medicare program (for example, from a rehabilitation hospital to a long-term hospital) is a new hospital, even if it continues to provide the same services as it did before the reorganization. To preclude hospitals from qualifying for a new hospital exemption based solely on such operational reorganizations or changes in certification status, we proposed to revise § 413.40(f) to specify that a hospital would qualify as a new hospital only if it had not previously provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program.

As explained in the June 4, 1992 proposed rule (57 FR 23659-23660), a hospital undergoing a change in organizational structure does not incur the significant patient care cost distortions associated with being a new hospital. Any cost distortions that affect the comparability of cost reporting periods stem from a change in the

organizational structure of the facility rather than in the type of services it provides to patients in the excluded portion of the facility.

However, we also recognized that the target amount that applied before the hospital's reorganization might not appropriately reflect costs after its reorganization. Therefore, to account for the effect of changes in the operational structure of the hospital or distinct-part unit (that is, a freestanding rehabilitation hospital becomes a distinct-part unit or vice versa) on operating costs per discharge, we proposed to revise § 413.40(b) to clarify that the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

In contrast, the target amount would continue to reflect the costs of a hospital that changes the basis of its certification but does not experience a significant change in organizational structure or in the type of services provided. The potential new hospital exemption period for these hospitals would begin with the first day of the cost reporting period in which the hospital provided services consistent with its new certification status. An example would be a new hospital with an average length of stay exceeding 25 days that changes its certification from an acute care hospital to a long-term hospital after 1 year. Since the hospital served the requisite patient population from the outset, the base year would be the first cost reporting period beginning at least 12 months after the hospital accepted its first patient as an acute care hospital.

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: A commenter argued that there may be cases where the established base year under the new hospital provision does not reflect the hospital's per-case costs because it could take a longer period of time before the on-going cost structure for a new hospital is in place. In cases where it is subsequently determined that the base year's per-case rates are distorted, a permanent adjustment to the base year per case rate should be made, so that these hospitals do not have to seek a payment adjustment to their per-case rates each year.

Response: The situation described above is not unique to new hospitals. There are many circumstances that could cause cost distortions between the base year and subsequent periods. Regulations at § 413.40(g)(1) currently provide the mechanism by which hospitals may receive adjustments

under the cost per case limitations. One general basis for an adjustment is lack of comparability between the base period and subsequent periods. To the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, and separately identified by the hospital, an adjustment may be warranted. If the cause of the cost distortion is permanent, the adjustment will be made permanent as well.

Comment: A commenter asserted that the existing new hospital exemption process provides the most effective incentive to reduce health care costs. Increases in hospital spending could be more effectively controlled through the existing new hospital exemption rules. The new hospital exemption was implemented in order to provide a hospital with enough to establish a good base of operations.

Response: We do not agree with the commenter that the current new hospital exemption more effectively controls hospital spending. During the exemption period, a hospital has little incentive to control its costs. Under the current exemption policy, a hospital may choose, after the fact, whether it wants its base year to be its initial year of operation (even though it may not be representative of its on-going costs), or its third year. Since the hospital knows in advance that it may choose either the first or the third year of operation as its base period, it has an incentive in both years to increase its costs in order to raise the target amount that would be applicable to subsequent periods.

The reason for allowing an exemption to the rate-of-increase limit during the early years of a hospital's operations is to recognize that certain cost distortions may be present when a hospital is beginning its operations. The first year of operation is commonly atypical. That is, there are normally start-up costs in the first year and utilization may be lower in that year. Since the first year is typically unrepresentative of the hospital's on-going operation, it should not be used as a base period. However, by the second year of operation, the hospital's operations should be well established. To provide an exemption beyond this period unnecessarily delays the incentives for cost containment imposed by the rate-of-increase limits.

Comment: A commenter suggested that in determining the base year per-case rate for a new hospital that is exempt from the prospective payment system, HCFA should select whichever cost reporting period, within two years after the hospital accepts its first patient, is most representative of the hospital's legitimate cost structure.

Response: We believe the commenter's suggestion would be problematic in that it would require including a subjective judgment in the selection of the base year. New hospitals that are exempt from the prospective payment system have an advantage over other hospitals already under the rate-of-increase ceiling since the new hospital knows in advance which period will be its base period and can react accordingly. One problem with the current provision is that the hospital has the flexibility to choose after the close of the potential base periods which period it wants as the base year. In some situations, hospitals have prematurely requested an exemption and later wanted to withdraw the request due to subsequent extenuating circumstances. Making the exemption automatic, and shortening its length, puts all new hospitals on the same footing with respect to the rate-of-increase ceiling. Any distortions after the base year can be addressed through the normal adjustment procedures.

D. Adjustments Under the Rate-of-Increase Ceiling (§ 413.40(g))

Section 413.40(g)(3) provides that HCFA may make an adjustment to take into account factors that will result in a significant distortion in the operating costs of hospital inpatient services between its base year and the cost reporting period subject to the rate-of-increase ceiling. Section 413.40(g)(3)(ii) was added in the August 30, 1991 final rule to clarify those circumstances under which HCFA may adjust the amount of operating costs in establishing the ceiling without a formal request from a hospital (56 FR 43232). Although this clarification was not intended to limit HCFA's authority to adjust base year costs to only those factors specifically stated in § 413.40(g)(3)(iii), we believe the current regulations could be interpreted to preclude HCFA from making adjustments except under the specified circumstances. However, there may be other cases in which the base period is not a representative base for adjusting future costs. This would include cases in which the hospital had extremely low Medicare utilization during the base period, or cases in which there was a significant change in Medicare coverage during the base year (for example, as a result of the Medicare Catastrophic Coverage Act of 1988). In such cases, the base period would not be appropriate for establishing a target amount for limiting cost increases in future periods. Therefore, we proposed revising § 413.40(g)(3)(iii) to specify the circumstances when HCFA may adjust the amount of operating costs. We

proposed that these circumstances include, but not be limited to, adjustments to take into account the factors set forth under § 413.40(g)(3)(ii) (A), (B), (C), (E) and (F).

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: Commenters recognized that there may be situations where it would be appropriate for HCFA to make adjustments to overcome distortions in the comparison of base year and current costs. However, they argued that the proposed unqualified wording ("certain adjustments" which "include, but are not limited to" those specified in the rule) invites arbitrary and inappropriate actions both in the determination of what constitutes a significant distortion and in the nature of the adjustment. Furthermore, there is currently no requirement that HCFA advise the hospital in advance or seek its participation in resolving a reputed distortion. The commenters recommended that HCFA expand the list of specific situations causing distortions, provide for HCFA's general adjustment authority in the context of regulatory language describing the nature of other possible situations that would constitute or result in significant distortions, and that HCFA be required to notify the affected hospital of the distortion that it intends to address, describe the proposed remedy, and permit the hospital to present its views and data in advance of HCFA making any adjustments.

Response: We do not believe the proposed language invites arbitrary and inappropriate actions. Although there may be similarities in some adjustment requests, each case presented for a determination, is to a certain extent, unique to the individual hospital. The examples cited in the proposed rule are cases we are aware of to date, but there may be other situations that have not come to our attention. It is almost impossible to develop an all-inclusive listing of circumstances that may warrant adjustments. Therefore, we believe it is important to permit some latitude in the adjustment process by addressing the most common circumstances in the regulation and allowing flexibility to address unknown circumstances. Anytime HCFA makes an adjustment, the decision is forwarded to the hospital's fiscal intermediary, which in turn notifies the hospital of the decision, including a full explanation of the grounds for the decision. The hospital has 180 days after the date of the intermediary's notice of the decision to appeal a determination.

E. Other Issues

We received two comments unrelated to the proposed changes. We considered the comments, but we do not intend to make any additional changes as a result of these comments.

Comment: Several commenters wanted to treat new distinct-part units that are exempt from the prospective payment system the same as new hospitals in terms of the initial exemption from the rate-of-increase ceiling and the determination of the base year.

Response: We proposed no changes to this provision of the Medicare regulations. However, we continue to believe that the new hospital exemption should not be extended to include newly established distinct-part units. The basic premises regarding the new hospital exemption are that new hospitals have incurred start-up costs to become operational and they need to build a relationship with the community. With respect to distinct-part units of a hospital, start-up costs should be minimal and the distinct-part unit, to some degree, has its own patient population already established through the acute care hospital. Thus, we believe the considerations which underlie the exemption to new hospitals do not apply to distinct-part units.

Comment: A commenter suggested that HCFA should allow the rebasing of any long-term hospital that can show that it is providing a significantly greater amount of routine and/or ancillary services per discharge or per day for medically necessary services. A significant segment of long-term hospitals' base years are distorted due to such factors as increases in Medicare utilization, increases in ancillary usage among Medicare patients, and changes in the PRO criteria since the base year.

Response: We did not propose any changes to the rebasing provisions of the regulations. The circumstances described by the commenter are already accounted for in the adjustment provision for comparability of cost reporting periods. One of the conditions of the assignment of a new base period is that the general TEFRA adjustment provisions would not result in recognition of the reasonable and necessary costs of providing inpatient services. Therefore, we do not agree that the change in rebasing provisions recommended by the commenter is necessary.

VIII. Other ProPAC Recommendations

As required by law, we reviewed the March 1, 1992 report submitted by ProPAC to Congress and gave its

recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 1, 2, and 11 concerning the update factors for inpatient operating costs are discussed in Appendix C to this document. The remaining recommendations on which we received comments are discussed below.

A. Updating Capital Payment Rates (Recommendation 3)

Recommendation: ProPAC recommends that a single update factor be developed for adjusting operating and capital prospective payment rates. The update framework should be consistent with that currently used by ProPAC to develop the prospective payment operating rate update recommendation and should be put into use for FY 1994.

Response: In the August 30, 1991 final rule (56 FR 43414), we established the capital update methodology to be used through FY 1995. Under that methodology, we will update the capital Federal rate and the hospital-specific rates for hospitals paid under the fully prospective payment methodology using a lagged 2-year moving average of actual increases in Medicare inpatient capital costs per discharge, adjusted for case mix index change. The capital update proposed in the Addendum to this *Federal Register* document is based on the average increase in Medicare inpatient capital costs between 1988 and 1990. The capital update established in FY 1995, the last year in which we will use the current methodology, will be based on the average increase in Medicare inpatient capital costs between 1990 and 1992. We established this methodology in response to hospital industry concerns regarding the uncertainty of the capital update over the first few years of the prospective payment system for capital-related costs. We believe that it would be inappropriate to change the method of updating capital payments before FY 1996, because of this desire of the industry for more certainty regarding capital updates.

We believe that it is appropriate to establish a capital-specific update framework until the prospective payment systems for capital-related and operating costs are unified in a single payment system. The development of an update framework for capital payment is conceptually and empirically more difficult than the development of a framework for updating operating payments. For this reason, and in order to solicit comments and to refine our framework, we included a preliminary discussion of an update framework for the capital prospective payment system in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43522). In the FY 1993 final rule, we will publish a more detailed discussion of the proposed framework, including an empirical illustration of the proposed update framework. This illustration will show the consistency and relationships of the framework with historical trends in operating and capital-related costs through 1990 and with the proposed FY 1993 update. Comments will be solicited on this framework, and we will provide successively improved frameworks in the final rules for FY 1994 and FY 1995. We will continue to solicit comments on these refined frameworks in order to improve the framework that will be adopted for FY 1996. Until this framework is appropriately refined, we believe that using the lagged increase in actual capital costs, adjusted for case-mix index change, is the most reasonable approach to take regarding capital updates.

Comment: ProPAC reiterated its recommendation that HCFA implement an update framework for fiscal year 1994 instead of using the 2-year average of historical cost-per-case increases.

Response: We present a preliminary discussion of an update framework for the prospective payment system for capital-related costs in Appendix D of this final rule. Section 412.308(c)(1) provides that HCFA will use a framework to determine the update factor beginning in FY 1996. We welcome comments on the preliminary concepts and methodologies for a capital update framework, and on the issue of whether framework update should be implemented before FY 1996 to determine the update factor.

B. Level of Indirect Medical Education and Disproportionate Share Adjustments to the Prospective Payment System for Operating Payments (Recommendation 4)

Recommendation: ProPAC recommends that the indirect medical

education adjustment to the prospective payment system for operating payments be reduced from its current level of 7.7 percent to 7.0 percent for FY 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

Response in the Proposed Rule: ProPAC's recommended reduction of 0.7 percentage points in the operating adjustment for indirect medical education (IME) represents approximately one-third of the difference between the current level of 7.7 percent (set forth at section 1886(d)(5)(B)(ii) of the Act) and 5.7 percent, which is ProPAC's most recent estimate of the effect of teaching activity on inpatient operating costs. That is, ProPAC estimates that for every 10 percent change in the resident-to-bed ratio, there is, on average, a 5.7 percent increase in Medicare inpatient operating costs per case.

ProPAC uses a statistical model to generate its estimate of the effect of teaching on Medicare inpatient operating costs that does not control for the hospital's costs of treating a disproportionate share of low income patients. Controlling for these costs would result in a substantially lower estimate of IME costs because of the overlap in hospitals receiving IME and disproportionate share (DSH) payments. We believe that it is appropriate to control for the effects of DSH status when estimating the effects of teaching. Not controlling for the effects of all of the payment variables would distort the results of the regressions by attributing some of the effects of the missing variables to the variables present in the regression. We strongly believe that payment for the indirect costs associated with graduate medical education should be based on the best estimate of the added costs incurred in treating Medicare patients and that payments in excess of this amount are an inappropriate use of Medicare trust funds. We further believe, as stated below in our response to ProPAC's Recommendation 5 with respect to the IME adjustment for capital-related costs, that the appropriate level of the IME adjustment is that currently paid in the prospective payment system for capital-related costs. This adjustment is based on regressions on total cost per case, controlling for all of the prospective

payment system payment adjustments, including DSH.

ProPAC further recommends that the reduction in IME payments for the prospective payment system for operating costs be returned to teaching hospitals that also receive DSH payments through a modification in the DSH adjustment for operating costs. We do not agree that the reduction in IME payments should be returned to teaching hospitals that also receive DSH payments. These hospitals currently have payment-to-cost ratios that are significantly higher than other hospitals. While we believe that it is possible to improve payment equity across all classes of hospitals by returning at least a portion of the IME payments to all hospitals, any such increase in payments to hospitals must be examined in the larger context of health care reform.

We strongly disagree that the low total operating margins (which are based on the facility's overall operations, not just Medicare patients) of DSH hospitals that also receive IME payments should be relevant to the distribution of Medicare payments. These lower total margins are associated with the fact that DSH hospitals that also receive IME payments tend to be faced with a broad array of social issues not directly related to Medicare patients, stemming largely from their location in urban areas and their role in providing services to low-income individuals. We continue to believe that social problems that are not directly related to Medicare beneficiaries should be addressed through more targeted policies rather than through indirect subsidies in the form of higher payments to a class of hospitals that are not underpaid relative to the costs of treating Medicare beneficiaries.

Comment: ProPAC had several comments on our response in the proposed rule to this recommendation. First, ProPAC agreed with our ultimate objective of one IME adjustment and one DSH adjustment for both the operating and capital prospective payment systems, but thought separate adjustments for operating and capital were necessary in the interim. ProPAC disagreed with our assertion that the estimate of the effects of teaching should control for the costs of treating a disproportionate share of low-income patients. ProPAC's position is based on its perception that the DSH adjustment is not intended specifically to reflect cost differences, but instead fulfills a broader public policy objective to maintain access to care.

In response to our statement that total operating margins are not relevant to an examination of Medicare payment policy, ProPAC argued that total margins are a useful analytic tool. For example, based on the relatively worse overall financial condition of teaching hospitals that serve a disproportionate share of low-income patients, as seen from these hospitals' low total operating margins, ProPAC commented that the savings from a reduction in the IME payment adjustment should be returned to these hospitals.

Response: As we noted above in our response in the proposed rule and in our response to Recommendation 5, below, we believe the adjustments for the operating and the capital prospective payment systems should be uniform. We have not, however, proposed changing the IME or DSH operating adjustments for FY 1993. These adjustments are specified in the statute.

We have serious concerns about ProPAC's rationale for not controlling for the costs of treating a disproportionate share of low-income patients in the estimation of the teaching effect. Numerous analyses have illustrated the interactive effects of IME and DSH on costs. We believe the payment adjustments should, as precisely as possible, reflect the actual cost impacts of the factors for which they are targeted. We have consistently maintained that the appropriate level of the IME adjustment should be one that is based on a more recent statistical estimate of the effects of teaching on costs, separate from all other factors for which hospitals' prospective payments are adjusted.

This position would seem to be consistent with Congressional intent, based on recent legislation. Since the DSH adjustment was implemented effective with discharges occurring on or after May 1, 1986, Congress has repeatedly acted to link the level of the IME adjustment to the level of the DSH adjustment. When the DSH adjustment was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), Congress simultaneously lowered the IME adjustment in section 9104(a) in recognition of the overlap of these two adjustments in terms of the hospitals receiving them. Similarly, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) further reduced the IME adjustment (section 4003(a)) to correspond with changes to the DSH payment policy (section 4003 (b), (c), and (d)). Finally, the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) deleted the expiration date for the

DSH adjustment (section 4002(b)(1)(A)) and correspondingly deleted the provision to increase the IME adjustment upon the expiration of the DSH adjustment (section 4002(b)(3)(B)).

Regarding the use of total margins to evaluate Medicare payment policy, we believe that our position is consistent with our argument that the IME estimate should reflect only the effect of teaching costs because the prospective payment system should, as precisely as possible, pay hospitals for their costs of treating Medicare patients efficiently. As we have stated in the past, we recognize the important role that large, inner-city hospitals play in fulfilling larger public health needs. However, as we have also indicated, we believe that social problems that are not directly related to Medicare beneficiaries should be addressed through more targeted policies rather than through indirect subsidies in the form of higher Medicare payments to all teaching hospitals. As we expressed in the proposed rule and above, the issue of equitably dealing with these larger social problems should be addressed within the context of health care reform.

Finally, as we have noted before, teaching hospitals that also receive DSH payments have consistently had Medicare payment-to-cost ratios above those of other hospital groups. Therefore, we disagree with ProPAC's recommendation that the savings from reducing the IME adjustment should be returned to teaching hospitals that also receive DSH payments.

Comment: One commenter supported our position that Medicare payment equity could be improved by returning at least a portion of IME savings to all hospitals. This commenter pointed out that the IME adjustment represents one component in the prospective payment system, and that savings from reducing IME payments should be used to close the gap between the Medicare operating margins of teaching hospitals and nonteaching hospitals. Another commenter expressed strong opposition to reducing the level of the IME adjustment until a within-DRG severity measure is developed.

Response: We take note of the first commenter's support for improving overall payment equity in conjunction with reducing the IME adjustment. Although we are concerned with the financial viability of large inner-city teaching and DSH hospitals, our responsibility in evaluating potential system changes includes the objective of overall payment equity. We believe this can best be achieved by ensuring that the payment adjustments accurately reflect the across-hospital variations in

Medicare costs due to the factors for which we make adjustments. Consequently, in response to the second commenter, we repeat our belief that the appropriate level of the IME operating adjustment is the level currently paid in the prospective payment system for capital-related costs. Because this estimate was made by controlling for case-mix variation using the FY 1991 GROUPE, it reflects our ability to control for the cost effects of varying levels of within DRG severity. To the extent that teaching hospitals have higher costs due to more severely ill patients that are not explained by controlling for case-mix, those costs would be reflected in the IME estimate. Therefore, we disagree with the argument that any reduction to IME should be delayed pending the adoption of a refined severity measure.

C. Consistency of Indirect Medical Education and Disproportionate Share Adjustments to Prospective Payment System Capital and Operating Payments (Recommendation 5)

Recommendation: ProPAC recommends that the same level of IME and DSH payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in FY 1994. Further, ProPAC believes that the methods of determining these adjustments in the prospective payments for operating costs should also be applied to the prospective payments for capital-related costs as follows:

- The measure of teaching intensity used for the IME adjustments should be defined in terms of the ratio of residents per bed.
- The criteria for designation as a DSH should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the prospective payment rate.

Response in the Proposed Rule: We agree with ProPAC that an appropriate policy would be to apply the same DSH and IME adjustments to the prospective payments for operating costs and for capital-related costs. However, we continue to believe that the appropriate level of the adjustments is that justified by the total cost regressions, as developed in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43378). That is, the adjustments for both operating and capital payments should reflect the effect on total costs

per case of IME and DSH status. We implemented these IME and DSH adjustments under the capital prospective payment system. We cannot implement them under the prospective payment system for operating costs since the IME and DSH operating adjustments are set by statute. Until we have statutory authority to change the IME and DSH adjustments to operating payments, we are faced with choosing between using different adjustments for capital and operating payments or making the IME and DSH adjustments to capital payments at the same levels used for operating payments. Since our regression analysis indicates the adjustments to operating payments are not reflective of the effect that IME and DSH status have on Medicare costs per discharge, we believe it would be inappropriate to use these adjustments for capital payments. Thus, we have decided to use different adjustments and base the adjustments to capital payments on the results of the total cost regressions.

With regard to the ProPAC recommendation that the criteria for designation as a disproportionate share hospital should be based on urban or rural location and number of beds, we believe that the only hospital groups that should receive the DSH adjustment are those with significantly higher costs due to their disproportionate share of low income patients. As explained in further detail in the August 30, 1991 final rule implementing the prospective payment system for capital related costs (56 FR 43378), we found no evidence in the total cost regressions that costs for any rural hospital grouping were significantly correlated with the DSH patient percentage. We also found no evidence that there is a correlation between the total costs per case of urban hospitals with fewer than 100 beds and their DSH patient percentage. For urban hospitals with at least 100 beds, we did not find a threshold disproportionate share patient percentage above which a higher adjustment formula was appropriate, nor did we find a threshold patient percentage below which no correlation between costs and patient percentage exists. For these reasons, we continue to believe that the DSH adjustment to capital payments, which provides an adjustment to only urban hospitals with more than 100 beds and does not require a threshold patient percentage, is correctly formulated and should apply to payments for operating costs as well.

We also disagree with the recommendation that the ratio of interns and residents to beds be used as the

measure of teaching intensity for the IME adjustment to capital payments. As discussed in the August 30, 1991 final rule (56 FR 43380), we believe that the ratio of residents to average daily census is a more appropriate measure of teaching intensity. Residency programs are intended to provide participants the opportunity to treat patients in a supervised setting. We believe that the indirect costs of a teaching program are more highly correlated with the ratio of residents to the average number of patients than with the ratio of residents to available beds, both occupied and unoccupied. This expectation is borne out by our regression results, which show both a smaller standard error and a slightly larger t-statistic when the resident-to-day ratio is used than when the resident-to-bed ratio is used in the cost regression.

In the August 30, 1991 final rule, we also stated our concern regarding the potential for manipulation of the bed count in order to increase teaching payments. In this regard, we note that the General Accounting Office, in its report on the IME adjustment for operating costs, refers to average daily census as a more "verifiable" statistic than beds. (A copy of this report, "Flawed Data Add Millions to Teaching Hospital Payments" GAO/IMTEC-91-31, June 1991, can be obtained by contacting the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877, or by calling (202) 275-6421.)

Comment: In its comments on the proposed rule, ProPAC stated that it continues to believe that the IME and DSH adjustments to the operating and capital prospective payments should be consistent. Also, ProPAC argued that the measure of teaching intensity used for capital IME payments, that is, the ratio of residents to average daily census, rewards hospitals with low occupancy rates. ProPAC was unable to reproduce our finding that the average daily census ratio performed better in explaining differences in cost per case. ProPAC believes that our regression results were based on total costs per case, and that our findings were due to lower occupancy hospitals having higher capital cost per case. As a result, ProPAC asserted that the use of the resident-to-day ratio rewards hospitals that use capital inefficiently. Finally, ProPAC suggested that the operating DSH formulas and criteria should be applied to capital payments, because of the public policy goals reflected in them. One commenter supported our position that the operating DSH adjustment should be made equal to the capital DSH adjustment. Another commenter

believed that the capital IME adjustment should be set equal to the current operating IME adjustment.

Response: We agree with ProPAC that the formulas and criteria of the operating and capital IME and DSH adjustments should be equivalent. However, we continue to believe that the appropriate level of the adjustments is that justified by the total cost regressions, as implemented in the capital prospective payment adjustments. As we stated above in our response to ProPAC's comments regarding Recommendation 4, we believe the payment adjustments should reflect the increase in the cost of treating Medicare beneficiaries due to increases in the resident-to-day ratio and the disproportionate share patient percentage, rather than any broader policy goals.

We disagree with ProPAC's position that the resident-to-day ratio rewards hospitals with low occupancy rates. ProPAC cites an example where two hospitals have the same numbers of residents and beds but different occupancy rates, so that the hospital with the lower average daily census would have a higher resident-to-day ratio. Focusing on occupancy rates obscures the fact that residents furnish services to patients and not beds. We believe it is intuitively appropriate to pay identical IME adjustments to hospitals with the same resident-to-day ratio but different resident-to-bed ratios, rather than the reverse. Therefore, although there would be a distributional effect of switching to the resident-to-day ratio for the operating prospective payment system, the result should more closely resemble the actual distribution of teaching costs. We also note that the capital IME adjustment formula results in a rising marginal rate of increase as teaching intensity rises. This would alleviate some of the distributional impact, since the current operating IME adjustment formula results in a declining marginal rate of change.

ProPAC indicates that it was unable to duplicate our findings of smaller standard errors and larger t-statistics in its regressions on operating costs using the resident-to-day ratio instead of the resident-to-bed ratio and assumes our findings are based on the combination of operating and capital costs as the dependent variable in our regressions. In fact, our analysis of a single standard rate operating prospective payment system yielded results similar to those for total costs. In that analysis, which focused solely on Medicare operating costs, the standard error of the log of the resident-to-bed ratio was .0467, and the

standard error of the log of the resident-to-day ratio was .0315. The respective t-statistics were 9.643 and 9.705. We would be happy to discuss these findings with ProPAC.

We disagree with ProPAC's suggestion that the better performance of the resident-to-day ratio in the statistical analysis is due to the higher capital costs per case of low-occupancy teaching hospitals with relatively high resident-to-day ratios. Based on this belief, ProPAC states that the resident-to-day ratio in the capital prospective payment system rewards hospitals for the inefficient use of capital resources. In fact, in a regression on FY 1988 and FY 1989 capital costs that controlled for occupancy levels, the resident-to-day ratio was significant and positive while the resident-to-bed ratio was insignificant.

Finally, we disagree with the commenter who believes the capital IME adjustment should be set at a level equal to the current operating IME adjustment. As stated in the proposed rule and repeated several times above, we continue to believe that the appropriate level of the IME and DSH adjustments are those justified by regressions on hospitals' total (operating and capital) Medicare costs, and adopted for the capital prospective payment system.

D. Medicare Transfer Payment Policy (Recommendation 7)

Recommendation: Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. ProPAC believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Response in the Proposed Rule: Since a Medicare discharge is the basis of payment under the prospective payment system, it is necessary to distinguish between discharges in which a patient has received complete treatment and discharges in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation irrespective of the length of time the patient spent in the sending hospital prior to transfer, this would create a

strong incentive to increase transfers, thereby unnecessarily endangering patients' health and increasing program outlays. Therefore, in a transfer situation, the regulations at § 412.4(d) provide that full payment is made to the final discharging hospital, and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred. The per diem rate is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the average length of stay for the DRG into which the case falls. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria, but are not eligible for day outlier payments. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) or DRG 456 (Burns, Transferred to Another Acute Care Facility), which are not paid on a per diem basis but receive the full DRG payment instead.

In the past, we have reviewed the transfer payment policy for potential improvements. The September 3, 1986 final rule (51 FR 31489) pointed out that, based on our analysis of the possible effects of making a single payment for all the hospitals involved in a transfer case, it was not possible to develop such a policy that would be equitable or administratively feasible. That is, we determined that a single payment based only on the DRG classification of one hospital would probably not be sufficient to be split equitably among the two or more hospitals based on the actual resources that each expended in the episode of care.

We issued a report to Congress in 1988 on the impact of outlier and transfer payment policies upon rural hospitals (Review of the Impact of Outlier and Transfer Payment Policy upon Rural Hospitals, DHHS, 1988). We examined the ratio of payments under the prospective payment system to total charges in the transferring hospital by length-of-stay and found that the ratios were actually highest for the shortest lengths-of-stay and declined as length-of-stay increased. Furthermore, the ratios for cases with lengths-of-stay of up to 3 days exceeded those for all inpatient stays paid under the prospective payment system. Although the focus of that report was primarily on the impacts of outlier and transfer policy on rural hospitals, it concluded that the current policy was more practical than another potential alternative,

establishing separate DRG categories for transfer cases.

ProPAC's report indicates that payment-to-cost ratios for transfer cases in the transferring hospitals were substantially below average for cases with short lengths-of-stay, but that the ratios were closer to average for cases with lengths-of-stay approximating the average. Since ProPAC's findings differ from those in our 1988 report to Congress, we intend to review ProPAC's results to determine whether refinements in the transfer payment policy are now warranted. (A ProPAC technical report containing the results of their analysis is scheduled for publication in April 1992.)

Any change in the transfer payment methodology needs to be evaluated in terms of its potential for creating incentives that may adversely affect the quality of care received by Medicare beneficiaries. For example, the declining per diem rate in a graduated per diem methodology would create an incentive for initiating transfers earlier in the course of treatment, potentially endangering patients' health. The magnitude of this incentive would depend on the gradation of the rate.

We share ProPAC's concern that the transfer payment policy not create substantial disincentives to the transfer of patients for recuperative care at a local hospital after completion of any specialty treatment provided in the tertiary hospital. However, we believe that, in light of the alternatives we have reviewed, our policy adequately maintains the efficiency incentives of the prospective payment system while establishing relatively neutral financial incentives to transfer or accept transfer patients. A decision to transfer a patient should be based upon the medical facts of a patient's case and not the financial effects upon the hospital.

Comment: In its comments submitted in response to the proposed rule, ProPAC reiterated its concern about the equity of the current transfer payment policy. In defense of its recommendation to pay transfer cases using a graduated per diem up to the full DRG payment, ProPAC cited a study conducted by RAND that shows average daily costs to be highest during the first part of a patient's stay. ("How Services and Costs Vary by Day of Stay for Medicare Hospital Stays," RAND Report No. R-3870-ProPAC, March 1990.) ProPAC urged HCFA to undertake further analysis of its current policy, pointing out that the differences between the findings in the 1988 HCFA Report to Congress and its more recent analysis could be due to differences in

accounting for the per diem payment for transfer cases.

Response: As noted in our response to this recommendation in the proposed rule, we have examined potential revisions to the current transfer payment methodology in the past without finding an acceptable replacement. We will continue to examine transfer payment alternatives and look forward to the release of ProPAC's technical report containing the results of its analysis of the current policy. However, until we review ProPAC's analysis, we can only speculate on the reason or reasons for the differences.

With regard to the analysis performed by RAND, we note that in its report RAND states that its sample "does not contain enough either small or rural hospitals for us to make reliable statements about this class of hospitals" (p. 19). The RAND report was not designed to evaluate transfer payment policy. In fact, the sample used by RAND is most representative of urban hospitals with 100 or more beds and is slightly overrepresentative of major teaching hospitals compared to the universe. In our 1988 Report to Congress on transfer policy, we reported that rural hospitals and urban hospitals with fewer than 100 beds tend to transfer larger proportions of their cases than do other classes of hospitals. In addition, our analysis in that report of the cost-to-charge ratios by length-of-stay focused solely on transfer cases, whereas RAND analyzed all cases discharged from the sample hospitals, including "true" discharges as well as transfer cases. These differences may explain some of the different findings. Treatment prior to release by a transferring hospital may be different than treatment provided by a hospital that treats the entire episode of care due to the unavailability of the often costly technology necessary to provide definitive treatment at the transferring hospital.

Comment: One commenter questioned our belief in the neutrality of the incentives of our current transfer policy, stating that the policy fails to distinguish between complex cases transferred for more sophisticated care, and cases transferred near the end of a treatment episode. The commenter described a systematic risk of underpayment to hospitals accepting a large number of patients that will ultimately require transfers, and a systematic overpayment to hospitals receiving transfer patients at the end of the treatment episode for recuperative care. Another point raised by this commenter in relation to the payment policy for transfer cases

concerned the exception to the policy made for DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility). The commenter believed the types of cases assigned to this DRG were too varied to ensure payment equity, ranging from newborns who receive very little care and die soon after birth to those who receive many days or even months of complex neonatal intensive care before death.

Response: We have no evidence that our current policy either systematically underpays for complex cases transferred out or systematically overpays for cases transferred in for recuperative care. A DRG is assigned to each hospital stay involved in a transfer situation based on the patient's principal and secondary diagnoses and treatment received. Therefore, the more complex needs of a patient during the early phase of a severe illness should be reflected by the DRG assignment. We reiterate, however, that we have devoted a good deal of effort to examining alternative methodologies in the past, and we remain interested in identifying refinements that could further reduce any financial disincentives to appropriately transferring patients for either a higher or lower level of care.

With regard to the commenter's second point, paying a per diem amount for DRGs 385 and 456 would result in an underpayment to the transferring hospital since the weighting factor for these two DRGs is based on the assumption that the patient will be transferred. Therefore, in the January 3, 1984 final rule, we provided for payment of the full prospective payment rate for transfer cases assigned to either of these two DRGs (49 FR 244). We note that, as shown in Table 7B of the addendum to this final rule, only 5 Medicare discharges were assigned to DRG 385 during FY 1991. Given this low volume of cases in the Medicare population, further differentiation would be impractical. Furthermore, hospitals are protected from inordinate losses for all transfer cases through cost outlier payments.

We note that this commenter represents a national association of children's hospitals, a group that is excluded from the prospective payment system. These hospitals are affected indirectly by the DRG classifications and weights through non-Medicare payers that model their classification and payment structure after Medicare's. As we note above in section II.B.6 of this preamble, given the low volume of pediatric patients covered by Medicare, this aspect of Medicare payment policy could produce anomalous results when

applied directly to payments for services to non-Medicare populations.

E. Payment for Hemophilia Blood Clotting Factor (Recommendation 8)

Recommendation: ProPAC believes that current prospective payment system policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, ProPAC may reevaluate this issue.

Response in the Proposed Rule: In 1989, ProPAC recommended implementation of a temporary, add-on payment for the costs of providing blood clotting factor to patients with hemophilia. ProPAC believed the add-on payment was necessary because of the rapidly increasing costs for clotting factor due in large part to manufacturing processes designed to reduce the risk of transmitting the human immunodeficiency virus. In response to ProPAC's recommendation, Congress enacted section 6011 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239), which amended section 1886(a)(4) of the Act to provide that hospitals paid under the prospective payment system receive an additional payment for the costs of administering blood clotting factor to hemophiliacs who are hospital inpatients. This add-on payment was effective for blood clotting factor furnished on or after June 19, 1990 and before December 19, 1991. A detailed discussion of this provision and its implementation can be found in the April 20, 1990 final rule with comment period (55 FR 15157) and the September 4, 1990 final rule (55 FR 36000).

ProPAC states that its analysis indicated that, in FY 1990, there were fewer than 3,000 Medicare discharges with hemophilia. Not all of them required blood clotting factor, and the vast majority of hospitals (94 percent) treated five or fewer cases. Therefore, ProPAC concluded that even though hemophiliacs are more costly to treat than the average case within a given DRG, there are insufficient data to indicate that these differences are due to the administration of clotting factor.

HCFA data analysis resulted in similar findings. Evaluation of hospital admissions in which blood clotting factor was administered (from June 19, 1990, when the add-on was implemented, to October 1, 1991) identified only 97 hemophilia inpatients. We found, as did ProPAC, that not only

was there a low volume of patients, but also, there were very few hospitals with a significant number of cases. Only eight hospitals administered clotting factor to four or more hemophilia patients. The impact of the increased cost of the clotting factor was distributed across 35 hospitals submitting claims for administering clotting factors to inpatients with hemophilia during the time period under analysis, with the majority of hospitals incurring only one admission.

As ProPAC states, the costs for the clotting factor are included in the hospital charges and are, therefore, reflected in the DRG weights. Under the prospective payment system, we do not pay for the costs of individual cases; rather, payment is based on an averaging process, as the cases in each DRG vary in resource requirements and length of stay. Given a normal distribution, most cases will require resources close to the average, with some cases costing more and some costing less. With the low volume of hemophilia inpatients requiring clotting factor, the higher costs for these cases are offset by the lower costs for other cases in the same DRG. In addition, the system does make provision for exceptionally high cost cases through outlier payments. Approximately 9 percent of the cases we analyzed received outlier payments.

We agree with ProPAC that, given the low volume of cases and the fact that these cases are not concentrated in a few hospitals, there is not sufficient justification to reinstate the add-on payment. Therefore, we support ProPAC's recommendation concerning the add-on payment for blood clotting factor provided to hemophilia patients.

Comment: We received three comments in response to our decision to discontinue the add-on payment for blood clotting factor administered to Medicare inpatients with hemophilia. The commenters all expressed concern that elimination of the add-on payment for blood clotting factor would result in significant underpayment to hospitals providing this service to Medicare inpatients with hemophilia who require blood clotting factor. These commenters believe that since the situation that led Congress to mandate a special payment for clotting factor remains unchanged, and the price of clotting factor remains high, eliminating the add-on payment must be expected to have an adverse financial impact on the hospitals that treat these patients. One commenter included data specific to his hospital that identified the magnitude of the differences between the cost of treating

hemophilia patients who require blood clotting factor and the Medicare payment received by the hospital for these cases.

Response: Since publication of the proposed rule, we have updated our evaluation of blood clotting factor administered to Medicare hemophilia inpatients. The most recent bill data contains all claims received through June 1992 from hospitals that administered blood clotting factor to hemophilia inpatients admitted between June 19, 1990 and December 19, 1991, the duration of the add-on payment. We compared the claims that contain codes for both a diagnosis of hemophilia (either as principal or secondary diagnosis) and revenue codes for blood clotting factor to all other hemophilia hospital inpatients for the same time period. As in our original analysis, we found that the costs experienced by hospitals administering blood clotting factor, while higher than the costs for all other hemophilia patients, are incurred by a small number of patients, and are distributed across hospitals in such a way that no one hospital is adversely affected in a significant way. Thus, results of our current review support the conclusions reached in our earlier data analysis, which was described in the proposed rule and repeated above. ProPAC continues to agree with HCFA that there is no need for an add-on payment for blood clotting factor.

Comment: Two commenters expressed concern that accounting for the cost of blood clotting factor in establishing the relative weights for all DRGs would be unlikely to yield adequate payment as the volume of cases is too small to have sufficient impact on the weights. One commenter believes including the charges in the relative weights would overcompensate hospitals generally without correcting

the underpayment suffered by other hospitals.

Response: The DRG relative weights are based on total charges submitted by all prospective payment hospitals. Because we could not identify specifically the charges for blood clotting factor as distinguished from the aggregate charges for all hemophilia patients, these costs were not excluded from the calculation of the DRG weights when the add-on payment was instituted. Thus, these costs have always been included in the charges used for establishing the DRG weights. Therefore, the add-on payment did not affect the aggregate charges used in calculating DRG relative weights.

Comment: We received one comment acknowledging that, for the Medicare population, there may be few hospitals facing a systematic risk of higher costs in treating hemophilia patients. However, this commenter believes that for children's hospitals that are paid under a DRG-type system for other than Medicare patients, there is substantial systematic risk. Therefore, the commenter requested that HCFA advise other payers that the payment policy that is appropriate for Medicare may not be appropriate in the case of a system that includes children and young adults.

Response: We have in the past, and continue to, caution against the use of Medicare DRGs that are developed based on a Medicare population for use with other populations. However, it would not be suitable for HCFA to advise other payers as to what may or may not be appropriate payment policy for their specific needs and populations.

F. Payment for Epilepsy Cases (Recommendation 9)

Recommendation: The current DRG assignment should be revised to account for the resource requirements of patients

with epilepsy receiving intensive neurodiagnostic monitoring. ProPAC analyzed Medicare data from FY 1990 to identify patients with epilepsy in DRGs 24, 25, and 26 (Seizure and Headache) and found that payment-to-cost ratios were lower for patients with epilepsy compared to other patients in the same DRGs. These payment differences were greater for patients with intractable epilepsy and for those receiving neurodiagnostic monitoring. The Commission also found that the majority of patients with epilepsy were not concentrated in any hospital type but that hospitals providing specialized epilepsy services had a higher percentage of patients with epilepsy who receive monitoring. Therefore, ProPAC believes that the Secretary should evaluate the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring.

Response in the Proposed Rule: HCFA analyzed FY 1991 MEDPAR data and identified 22,223 discharges with a principal diagnosis of epilepsy in DRGs 24, 25, and 26. Although epilepsy represents 29 percent of all patients classified to these DRGs, intractable epilepsy accounts for only 3.7 percent (2,780 cases). Our findings parallel those of ProPAC, with epilepsy cases diagnosed as intractable having higher average charges (\$7310) than the nonintractable cases (\$6274). These charges compare to \$6393 for all cases classified to DRG 24, 25, and 26. The following table summarizes the comparison of average charges between epilepsy and other cases assigned to the same DRGs. For each entry, the number of cases is included in the parentheses.

DRG	Intractable epilepsy	Nonintractable epilepsy	All epilepsy	All cases
24.....	\$8,867 (1,606)	\$7,260 (13,727)	\$7,440 (15,333)	\$7,400 (53,661)
25.....	\$5,027 (1,173)	\$3,901 (5,700)	\$4,093 (6,873)	\$3,977 (22,386)
26.....	\$4,070 (1)	\$5,959 (16)	\$5,848 (17)	\$7,174 (54)
All cases.....	\$7,310 (2,780)	\$6,274 (19,443)	\$6,403 (22,223)	\$6,393 (76,101)

If video and radio-telemetered electroencephalographic monitoring (procedure code 89.19) is performed, the result is higher charges, with both intractable and nonintractable patients receiving this service averaging a charge of \$7215, while those without the service

had an average charge of \$6471. The differential in charges for intractable epilepsy cases with and without telemonitoring service, however, was less than 3 percent. With only 2 percent of the cases reporting codes for video-telemetering, and only two cases

reporting psychological services, it is impossible to reach a definitive conclusion concerning the use and cost of neurodiagnostic services.

Evaluation of ancillary charges resulted in similar findings. That is, average ancillary charges were slightly

above average for intractable patients and slightly below for nonintractable patients. Since 90 percent of the epilepsy admissions are for nonintractable cases and only 10 percent are for intractable, these slightly higher treatment costs for intractable cases are distributed across DRGs 24, 25, and 26, with some charges occurring above the average and some below. Given this distribution of cases, the average ancillary charge for all epilepsy patients (\$3,431) was actually lower than the average charge for all patients in these DRGs (\$3,541).

To measure the impact on hospitals of providing services to patients with intractable epilepsy, we evaluated utilization by these patients at the hospital level, identifying high-volume hospitals (defined as hospitals treating 10 or more intractable epilepsy cases). We found that for intractable epilepsy patients, there were 1,042 hospitals providing service to 2,780 patients, with fewer than 4 percent of these hospitals having 10 or more cases (40 hospitals). Only 22 percent of the claims submitted by the high-volume hospitals for intractable epilepsy patients had charges that were higher than the average charge for the DRG for all patients. In addition, for approximately one-half of the claims submitted by these hospitals for all epilepsy patients in DRGs 24, 25, and 26, the average charge for treating intractable cases was less than the average charge for treating nonintractable cases.

Our evaluation of the relationship between Medicare costs and Medicare payments, for the first 7 years of prospective payment, identified only three high-volume hospitals with a negative average Medicare operating margin. (A negative operating margin means that a hospital incurred costs in excess of payment for its Medicare patients.) Without a high concentration of cases in a few hospitals, the impact of treating intractable epilepsy is distributed across many hospitals treating a low volume of these patients, with no significant impact on profit margins. This is consistent with the overall design of the prospective payment system. Under that system, payment is based on an averaging process, with some cases incurring costs in excess of payment while for others payment exceeds costs. The incentive is for hospitals to treat a mix of patients and, thus, achieve a balance between costs and payments.

As part of our analysis, we also examined the charge data from those 25 hospitals that were identified by the National Association of Epilepsy Centers as hospitals that specialize in

the treatment of epilepsy. Based on our data, these epilepsy specialty centers did not necessarily treat a high volume of Medicare intractable epilepsy patients. The volume of these cases ranged from 0 to 34. In addition, there was no consistent pattern concerning charges for either intractable or nonintractable epilepsy. The 10 specialty hospitals that were also high-volume hospitals (that is, treated 10 or more epilepsy cases) had average charges lower than the national average for these cases. We evaluated Medicare operating margins for the specialty centers, again reviewing the relationship between cost and payment for treating Medicare patients. As with the high-volume hospitals, the overall average operating margin for the first 7 years under prospective payment was positive. Only two centers (one of which was also a high-volume hospital) experienced an overall negative operating margin.

As ProPAC suggested, HCFA has evaluated the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring. While the results of our analysis confirm that intractable epilepsy patients incur higher charges on average than do patients with nonintractable epilepsy, particularly those receiving neurodiagnostic monitoring, these differences are not significant enough to warrant any DRG classification change.

We note that the data for both intractable and nonintractable cases were inconsistent across DRGs as well as among hospitals. Without accurate coding for the intensive services required for these patients, we cannot document consistent and reliable differences between patients receiving neurodiagnostic services and those not using these services. With minimal differences in average charges between intractable epilepsy cases and those of the DRG overall, given the distribution of cases across a large number of hospitals and the inconsistencies between both the high-volume hospitals and the epilepsy treatment centers, we find there is insufficient evidence to justify a DRG modification at this time. Therefore, we are not proposing any revision to the current DRG assignment for epilepsy patients.

We received several comments concerning the DRG classification for patients with intractable epilepsy. These commenters all disagreed with our decision not to make any changes in the current structure of DRGs 24, 25, and 26. The specific comments and our responses follow.

Comment: Commenters objected to the findings of our data analysis, stating that the data failed to identify charges for intractable epilepsy patients admitted for comprehensive medical evaluations, did not sufficiently distinguish those patients receiving neurodiagnostic monitoring, and was not representative of the true cost of diagnosing and treating intractable epilepsy patients. Many commenters questioned why the results of our analysis differed from ProPAC's findings and requested that we reconsider our decision and implement ProPAC's recommendation. In its comments, ProPAC reiterated its recommendation to modify the current DRGs to recognize the increased costs of treating patients with intractable epilepsy.

The commenters urged us to reassess our data, citing the failure of the present DRGs to account for the complexity and scope of the multidisciplinary services provided by hospitals that treat intractable epilepsy patients. Commenters recognized that additional procedure or diagnostic codes might be necessary to identify correctly the patients and services applicable to a new or revised DRG. In addition to offers to provide information and to assist HCFA efforts in DRG restructuring, a few commenters included data specific to their hospitals to supplement and enhance the reliability and validity of our data analysis.

Response: Since publication of the proposed rule, we have reexamined our analysis of both intractable and nonintractable epilepsy cases using the latest update to the FY 1991 MEDPAR file (June 1992). Our reassessment of these data confirms our prior conclusion that, although intractable epilepsy patients, particularly those with video-telemetered monitoring, do incur higher charges than patients without intractable epilepsy or telemetry, those differences are not currently of significant magnitude to justify a new DRG or other modification to the existing DRGs for these cases.

In response to assertions that our data do not truly represent the cost of caring for intractable epilepsy patients, we note that the data we analyzed for this issue and the results presented in the proposed rule included charge and coding information from all the FY 1991 bills received in HCFA as of December 1991. Our updated analysis includes the additional FY 1991 bills received in the 6 months following that date. The MEDPAR file contains 100 percent of the fully-coded Medicare claims submitted by hospitals and includes both the total

and covered charges. Thus, it is the coding and charge data submitted by hospitals themselves that are used during our DRG classification analyses. Accordingly, our analysis of the cost of caring for intractable epilepsy patients is based on data submitted by hospitals.

We used ICD-9-CM procedure codes 89.10 (Intracarotid amobarbital test) and 89.19 (Video and radio-telemetered electroencephalographic monitoring) to identify the complex patient subset of the entire intractable epileptic population. With the expansion of space on the HCFA UB-82 claim for reporting inpatient services from three to six fields, future data should be more comprehensive and complete. In addition, we note that this same extra space could be used in delineating the complex intractable epilepsy patients from the less complex patients. In past years, attempts have been made to obtain better coding of the diagnostic components of the comprehensive medical evaluation of intractable epileptics. Procedure codes 89.10 and 89.19 are a result of these attempts. We believe that it may be possible to develop additional codes to identify these patients. Therefore, we plan to include this topic on the agenda for the next meeting of the ICD-9-CM Coordination and Maintenance Committee (December 3, 1992).

While we appreciate the resource-use data for intractable epilepsy patients from specific hospitals included with some of the comments, the use of MEDPAR data ensures standard, uniform, unbiased information across all Medicare hospitals. Hospital-specific data from the provider community are used to enhance our understanding of the problem under analysis, but cannot be used to determine payment policy. ProPAC agreed with our finding that more accurate codes for intensive services for intractable epilepsy patients may need to be implemented. We encourage hospitals to use accurate coding and to furnish HCFA with information that would help improve the codes that are available to reflect the treatment being administered. Although our conclusions differ from those of ProPAC, we did consider its recommendation and evaluated our data in light of the results obtained by the ProPAC study. However, based on the number of cases in the MEDPAR file and the relatively small difference in average charges between intractable epilepsy cases and all other cases in DRGs 24, 25, and 26, as well as our assessment of the impact these cases have on the specialty or high-volume hospitals, we continue to believe that

there is insufficient evidence to justify a DRG revision at this time.

Comment: Many commenters stated that HCFA's analysis failed to take into account the level of care received by intractable epilepsy patients in highly specialized epilepsy treatment centers. These commenters believe that, in analyzing the data, HCFA did not differentiate between the highly specialized centers and general acute care hospitals treating epilepsy patients with shorter and less expensive lengths of stay. One commenter expressed concern that the sampling method used was inadequate, stating that the majority of patients in our analysis were treated at acute care general hospitals for an intermittent problem related to their intractable epilepsy and, therefore, incurred shorter lengths of stay. Some commenters compared the length of stay experienced by intractable epilepsy patients admitted to specialty centers (approximately 2 to 5 weeks) with the geometric mean lengths of stay printed in Table 5 of the addendum to the proposed rule. (The geometric mean lengths of stay in that table were 5.2, 3.4, and 3.9 days for DRGs 24, 25, and 26, respectively.) They stated that the current DRG system, which is based on average resource use, does not account for the higher number of severely ill intractable patients found in these centers. The commenters assert that, for these hospitals, the averaging process inherent in the DRG classifications and the prospective payment system as a whole does not work. One commenter is concerned that we did not consider differences in the level of care available at an individual hospital. To ensure appropriate, equitable payment, the commenters recommended establishing a new DRG or modifying the present DRG to accommodate the additional costs incurred by the level of service available at these specialty institutions.

Response: In our analysis of epilepsy data for the proposed rule and the updated analysis conducted for this final rule, we evaluated the performance of acute care general hospitals and epilepsy treatment centers both as a group and separately. In our analysis, we did not use a sample of these hospitals, but rather 100 percent of the FY 1991 discharges from all hospitals for all epilepsy patients, both intractable and nonintractable. In our analysis for all hospitals, we focused on the high volume providers, defined as those treating 10 or more patients with intractable epilepsy in a year. Our most recent findings are similar to those set forth in the proposed rule, with only 25 percent of the high-volume hospitals

incurring average charges in excess of the mean charge for all intractable epilepsy cases.

As in our previous analysis, we examined the experience of the epilepsy treatment centers. Our current findings, however, are more comprehensive than those for the proposed rule, as we were able to identify 52 epilepsy centers (rather than 25 as in the proposed rule). For these 52 hospitals, 8 had no Medicare epilepsy discharges in FY 1991; of the remaining 44 hospitals, 42 treated at least one Medicare intractable epilepsy patient. The results of this analysis parallel those presented in the proposed rule. As was the case in the previous analysis, the epilepsy specialty centers did not necessarily treat a high volume of Medicare intractable epilepsy patients. The number of patients for FY 1991 at the 42 centers ranged from 1 to 38. Considering only the 42 specialty hospitals that treated intractable epilepsy cases in FY 1991, we identified 15 hospitals where the average charge for nonintractable epilepsy cases exceeded the average charge for treating patients with intractable epilepsy. As we also found in our original analysis, the charges for patients with intractable epilepsy were highly variable, with 13 (72 percent) of the 18 high-volume hospitals (those with 10 or more cases) reporting average charges below the mean for all intractable epilepsy patients.

Although length of stay is one indicator of resource use, it is not one of the factors used in establishing DRG weights. More to the point, the geometric mean length of stay is used by HCFA to establish the outlier threshold for day outlier cases and is not relevant to other payment issues. A more illustrative statistic for the commenters' purpose is the arithmetic mean (average) length of stay for a DRG. In fact, the arithmetic mean lengths of stay for DRGs 24 through 26 are somewhat higher than the geometric—7.2, 4.3, and 5.9 days, respectively. (See Table 7B of the addendum to this final rule.)

The prospective payment system methodology ensures that all cases are included in establishing the weight for the DRGs. As payment is based on averages rather than individual cases, there will be cases that fall below the average and others that fall above the average. Outlier payment is provided for cases incurring excessive lengths of stay or high costs. We recognize the commenters' concerns that the averaging process may fail to address the special populations at epilepsy treatment centers. We intend to continue to monitor this situation, and

will explore whether improved codes can be used to identify these cases and review the charges in the FY 1992 MEDPAR data.

Comment: Many commenters objected to our use of Medicare operating margins as supporting documentation for our decision not to modify the DRG classification system to account for intractable epilepsy patients. These commenters stated that analysis of profit margins was inappropriate in determining the DRG classification, and that the classification system should be based on a combination of the patient's diagnoses, condition, services provided, and resources used during the patient's hospitalization.

Response: We believe that using Medicare operating margins as one indicator of the financial impact of Medicare payment on individual hospitals is appropriate. This variable provides perspective on total hospital resource use and payment under the prospective payment system. As noted, above, payment under this system relies on an averaging process both within a given DRG, as well as across all DRGs. Thus, while some cases within a given DRG will receive payment in excess of costs while others will receive payment below costs, this is equally true for the hospital's cases as a whole. There are DRGs for which payment to a particular hospital exceeds costs, just as there are DRGs for which the hospital receives payment below the actual cost of delivering service. The incentive to the hospital is to manage its operations more efficiently by evaluating those areas in which increased efficiencies can be instituted without affecting the quality of care and by treating a mix of patients to balance costs and payments.

Assignment to a DRG is based on a combination of patient diagnoses, procedures, age, and discharge status. The resources used during a patient's hospitalization are measured by total charges, which are the basis for establishing the DRG relative weights. A hospital's profit margin is not a factor in determining DRG classification. However, when questions arise concerning whether a hospital's loss on a particular set of Medicare cases is undermining its ability to provide its services to the Medicare population overall, we believe that considering the hospital's Medicare operating margin is appropriate. The decision not to implement modifications to the DRGs for intractable epilepsy was based on our total evaluation of hospital experience in treating these patients, and not on the operating margin of the specialty or high-volume hospitals.

Comment: Several commenters referred to the age of their patient population, stating that most of the Medicare patients receiving comprehensive treatment for intractable epilepsy are under age 40. These commenters stated that a DRG modification assuring appropriate payment would be cost beneficial in the long run, providing a predominantly young population suffering from intractable epilepsy the treatment to allow them to assume productive lives.

Response: Medicare data confirm that the population of intractable epilepsy patients contains more patients under age 65 than is typical. However, a very high proportion of the patients in our data are in fact over 65 years of age. With an average age of 65 or greater at more than 50 percent of the hospitals, we do not believe it is feasible to use age as a criteria for assigning DRG classification for intractable epilepsy patients. Every effort is made to ensure that payment for Medicare patients encourages maximum benefit and does not impede access to care.

Comment: Some comments included references to surgical treatment for intractable epilepsy patients, citing specific examples of cases receiving surgical care and their successful outcomes. One hospital, which evaluates patients with intractable epilepsy for epilepsy surgery, stated that they were significantly underpaid under Medicare for these patients. Commenters requested an adjustment to the current payment system to accommodate these inequities between cost and payment.

Response: Patients diagnosed with a principal diagnosis of intractable epilepsy who have a surgical procedure performed during the same admission are classified to surgical DRGs, not to DRGs 24, 25, and 26. There were 351 discharges during FY 1991 with a principal diagnosis of intractable epilepsy and the performance of a surgical procedure. Of these, 79 percent were assigned to DRG 1 (Craniotomy Age > 17 Except for Trauma), which currently has a relative weight of 3.2322. We have received no indication that the DRG 1 payment does not adequately compensate hospitals for intractable epilepsy patients who have surgery and our discussions with representatives of the hospital community identified the payment for DRGs 24 through 26 as the area of concern. Therefore, we concentrated our analysis on medical treatment, particularly neurodiagnostic monitoring and comprehensive medical evaluation of intractable epilepsy patients.

G. Essential Access Community Hospital Program (Recommendation 10)

Recommendation: ProPAC recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, ProPAC believes that overall system efficiency may be improved without sacrificing access to care.

Response in the Proposed Rule: On October 25, 1991, we published a proposed rule in the *Federal Register* to implement the Essential Access Community Hospital (EACH) program, including criteria that facilities would have to meet to qualify to be designated as EACHs or rural primary care hospitals (RPHs) (56 FR 55382). These criteria were based on the provisions of section 1820 of the Act (the statutory section that establishes the EACH program). That section of the Act does not include any mechanism for waiving the statutory requirements for designation as an EACH or RPH.

In response to our proposed rule, we received a number of comments recommending greater flexibility in the application of the statutory provisions cited by ProPAC, including the criteria for designation as an RPH. The provisions for which commenters recommended waiver included those provisions relating to the certification of the need for temporary inpatient care, the bed-size and length-of-stay limitations for RPHs, and the criteria related to the bed size or location of EACHs and their responsibilities with respect to RPHs. Some commenters expressed the opinion that HCFA should waive some or all of these provisions; other commenters recommended that we publish final regulations to permit the designation of "intermediate EACHs" that would appear to be similar in concept to the larger facilities that ProPAC believes should be encouraged to become more efficient through appropriate restructuring of their services.

We are considering these comments and will respond to them in the preamble to the final rule implementing the EACH program. We do not believe it would be appropriate to adopt any of

the ProPAC recommendations outside of the rulemaking process.

Comment: ProPAC suggested, as did some commenters in response to the proposed RPDH regulations published on October 25, 1991 (56 FR 55382), that the Secretary has broad authority under section 1820(j) of the Act to waive various provisions of the EACH program, as set forth in section 1820 of the Act, in order to induce eligible hospitals to participate.

Response: As explained in our response to this recommendation in the proposed rule (57 FR 23665), we are considering all public comments with regard to the EACH proposals. Because this issue is under consideration in developing the final EACH regulations, we do not believe it would be appropriate to respond to ProPAC recommendations regarding it at this time. However, we will respond fully to the comments on this issue in the preamble to the final EACH regulations.

H. Update Factor for Payments to Dialysis Facilities (Recommendation 12)

Recommendation: ProPAC is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. ProPAC recommends that HCFA expedite work necessary to complete its data base of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis facilities and maintain a data base with this information.

Response in the Proposed Rule: Section 4201(b) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) directed ProPAC to conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease (ESRD) patients under the Medicare program. Based on this information, ProPAC was directed to make recommendations to Congress regarding the method or methods of payment and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under Medicare should be established for dialysis services furnished during FY 1993 and the methodology to be used to update these payments for subsequent fiscal years. These recommendations were to be submitted as a report to Congress by March 1, before the beginning of each fiscal year, beginning with March 1, 1992 for FY 1993. The study requires ProPAC

to examine the following factors: Hemodialysis and other modalities, adjustment factors for facility's characteristics, adjustments for labor and nonlabor costs, profit margin, and adjustments for patient complexity and costs associated with positive outcomes.

ProPAC believes that existing evidence, based on 1988 audit data, does not justify a rate increase at this time. However, ProPAC concluded that the 1988 audit data were not representative of the proportion of patients treated at home, the types of dialysis provided, and the characteristics of all dialysis facilities. Thus, the Commission concluded that this sample was not adequate to address the issues raised by Congress in Pub. L. 101-508 and that more extensive cost data was needed. The 1988 audit sample was designed to estimate the median costs of a dialysis service in an efficiently operated renal facility, that is, to set a rate for payment, and not to determine the costs of dialysis services that were affected by other factors (such as volume, type of ownership, and location of facility) as referenced by the statute.

We agree with ProPAC's assessment that the 1988 audit data were not sufficient to address the issues raised by Congress, as the audits were not designed to provide data on the issues raised in the Congressional mandate. We are maintaining computer files of cost report data for independent renal facilities with fiscal years ending in 1989, 1990 and 1991, and for hospital renal facilities with fiscal years ending in 1990 and 1991. ProPAC is in the process of analyzing these data.

ProPAC is also recommending that we annually audit a representative sample of cost reports to use in evaluating payments and costs by type of treatment and setting. This is an appropriate recommendation for rate-setting purposes, but we do not believe it would be cost effective to conduct annual audits under the prospective payment system, since there is no recovery of Medicare funds to offset the costs of these audits. Also, section 4201(a) of Pub. L. 101-508 limited the Secretary's authority to set rates. With respect to ProPAC's recommendation regarding audits, we believe that the audits should be conducted, and the results should be used to set payment rates. We believe that to conduct audits without using these results to set rates would result in inefficient use of government expenditures.

In this final rule, we are not republishing the tables included in the June 4, 1992 proposed rule (57 FR 23667) that contained patient data from the ESRD Facility Survey. The tables were

included in that notice to summarize the number of patients on the different treatment modalities. The tables showed that 95 percent of dialysis patients are on either outpatient hemodialysis or continuous ambulatory peritoneal dialysis. We presented this information for ProPAC to consider in revising the payment methodology for dialysis services.

When the base rates were originally established, they were weighted using the cost experiences of small renal units, especially hospitals, which then dominated the dialysis industry. This resulted in overpaying the more efficient larger facilities. This imbalance could be eliminated by establishing different rates for the larger, more efficient renal facilities that benefit from economies of scale. For facilities that meet certain limited criteria, a different payment structure based on the characteristics of these facilities might be considered. For example, pediatric hospitals could have their own payment rate, and small rural facilities, with less than a defined number of treatments (for example, 4,000 treatments) could have their payment rates adjusted to reflect the financial disadvantages associated with low volume. For hospitals, a case-mix adjustment would be appropriate to eliminate the administrative burden and costs borne by hospitals filing for exceptions to their payment rates.

In 1990 the treatment modalities for 97 percent of renal patients were outpatient hemodialysis, CAPD (continuous ambulatory peritoneal dialysis) or CCPD (continuous cycling peritoneal dialysis). The percentage of patients on hemodialysis and CAPD continues to grow. Any new rate structure should reflect this trend and account for the decrease in the number of intermittent peritoneal dialysis (IPD) and home hemodialysis patients.

Comment: ProPAC expressed its disappointment that HCFA does not play to audit a representative sample of cost reports.

Response: Conducting annual audits results in substantial expenditures of resources. Auditing not only affects government spending but also spending by intermediaries and renal facilities in the audit sample. Before deciding to conduct audits, it is critical to define the goal of these audits. This is important, since the last three sets of audits have not been used to revise payment rates; in fact, section 4201(a) of Pub. L. 101-508 prohibits HCFA from changing the current composite rates.

In lieu of conducting annual audits, we suggest that the same sample group of renal facilities be analyzed on an

annual basis. ProPAC and HCFA would initially select this group of facilities and would analyze these same facilities' cost reports on an annual basis. HCFA would audit a facility's cost report on a variable basis or when the data warranted one. This format would provide ProPAC, HCFA, and Congress audited historical data of the costs to furnish a dialysis treatment. Furthermore, using the same facilities' cost reports would track the Medicare costs of a dialysis treatment over time.

With the advent of facilities submitting their cost reports electronically, renal cost data are now available to satisfy the program's responsibility of gauging dialysis costs. At this time, we do not plan to audit these data on an annual basis.

Comment: One commenter was under the impression that HCFA's suggestions are recommendations that we are trying to implement.

Response: Our suggestions are only factors that we believe ProPAC should examine before making final recommendations to Congress as mandated by section 4201(b) of Pub. L. 101-508. This law requires ProPAC to examine the effect that size, location, type of facility, and mix of services has on the costs of furnishing a dialysis treatment.

Comment: One commenter stated that the 1988 audit sample was inadequate since it represented only a 5 percent sample, included a high proportion of large facilities, and consisted of old data.

Response: The 1988 audit sample was scientifically designed to determine the median cost of furnishing a maintenance dialysis treatment in an efficiently operated renal facility. We did not design the audit sample to determine the costs of dialysis treatments in different types of renal facilities. ProPAC realized the limitation of the audit sample and stated that it was not adequate for the type of study mandated by section 4201(b) of Pub. L. 101-508. Although ProPAC decided not to use the audit data for its study, they believed the audit data did not justify a rate increase.

The sample size of 5 percent was adequate for determining the median cost of a maintenance dialysis treatment. Selecting a larger sample size would have an insignificant statistical effect on the confidence level in estimating the median cost of a dialysis treatment.

We do not believe the age of the data is a critical problem. Based on the results of the prior three audits, using the more current audit data in the payment formula has consistently produced lower payment rates. These

audits consistently showed a decrease in Medicare costs of independent renal facilities, while hospitals' costs showed little variation.

To conduct audits and prepare a Federal Register notice would take about 18 months. Using current year audited cost data would delay any final notice for at least 18 months. Using unaudited data would expedite the process of revising payment rates. With the advent of renal facilities submitting their cost reports electronically, revising the composite payment rate using more current data could be accomplished more timely. Of course, this can only happen if renal facilities complete their cost reports timely and accurately.

Presently, independent facilities submitting cost data do not adhere to all the Medicare reimbursement principles in completing their cost reports. Cost data submitted by hospital facilities show wide ranges in the cost per treatment by treatment modality. From our review of the data, it appears that some hospitals are not completing their cost reports properly, resulting in incorrect allocation of costs. Until the data become reliable, updating payment rates using the most current unaudited data is not prudent. To help ensure timely and accurate payment revisions, renal facility administrators should verify that their facility cost reports are correctly prepared.

Comment: Two commenters objected to our suggestion that ProPAC consider a payment method that establishes different rates for the larger more efficient facilities.

Response: We are not suggesting that ProPAC penalize the larger more efficient facilities. We merely emphasize that a payment methodology that matches payment with expenditures should be considered. The present composite payment rate formula combines the cost experiences of all renal facilities to establish a single payment rate. Such a methodology penalizes the small rural facilities, pediatric facilities and backup hospitals that furnish dialysis treatment to ESRD patients requiring more medical resources. This methodology also inflates the amount paid for a maintenance dialysis treatment by using the cost experiences of smaller facilities. We believe that the payment rates should reflect the fact that 57 percent of all dialysis facilities furnish 83 percent of all dialysis treatments, and should account for the cost experience of small facilities or inefficient facilities. As part of the study mandated by Congress, ProPAC will examine what effect size, location, type of facility and mix of services has on a facility's costs.

Comment: Two commenters stated that the case mix adjustment should apply to all facilities, not just hospitals. In the proposed rule, we had recommended that ProPAC consider a case-mix adjustment for hospitals only.

Response: There is no study that clearly documents that one type of facility treats a sicker ESRD patient population than another type of facility. To date there is no medical definition of an atypical ESRD patient population. Until there is a clear definition, we are limited to assumptions regarding atypical patient mix based on patient characteristics.

During the last three exception windows, no independent renal facility was granted a rate increase because of an atypical ESRD patient mix. Generally, patient characteristics of independent renal facilities are not aberrant when compared to national ESRD patient characteristics. Furthermore, independent renal facilities have the option to transfer a sicker patient to their backup facility when the patient's condition requires more intense medical services. ProPAC will examine the possibility of adjusting payment rates to reflect a case-mix index. Such an index would ensure a matching of revenues with medical resources consumed by ESRD patients.

Comment: One commenter proposed that ProPAC structure a new payment methodology similar to the hospital prospective payment system that includes payment for outliers and exceptions.

Response: HCFA is suggesting that ProPAC consider a payment system that is adjusted for a case-mix index and provides different payment levels for pediatric and small rural facilities. We do not believe it is appropriate to make the exception process more complex, since most facilities already believe this process is burdensome and costly.

Comment: One commenter agreed that there was a shift in treatment modalities but did not agree with the conclusion that the rate should be adjusted to reflect this trend. The commenter suggested that because of this shift blended costs of all dialysis treatments has increased compared to the data used to set the original base composite rates.

Response: The commenter incorrectly assumes that HCFA is recommending a rate reduction because of changes in the type of dialysis being furnished. HCFA only summarized patient data in the June 4, 1992 proposed rule to show the shift in treatment modalities. We made no recommendations to ProPAC that the composite payment rate should be

reduced because of this shift. We suggested that ProPAC should take into consideration the increase in CAPD and CCPD in any rate structure. We brought this to ProPAC's attention because most owners of renal facilities argue that these forms of dialysis are more costly.

Comment: Two commenters disagreed with our statement that if ProPAC recommends a separate home dialysis rate, only those facilities that have a significant home patient population should be used to establish the payment rate to reflect the economic efficiencies and training expertise of such programs.

Response: One commenter misunderstood our discussion of the costs of home dialysis. We are not suggesting that the payment methodology exclude hospital facilities in computing new rates. On the contrary, hospitals have a higher percentage of home dialysis patients than independent renal facilities. To use all home dialysis programs in setting a payment rate for home dialysis would result in small or inefficient programs overstating the costs to furnish home dialysis in an efficiently operated facility. Audited cost data reveal that renal facilities with large home programs (home costs in excess of \$1 million) tend to report home costs properly. Renal facilities with small home programs generally fail to report or to allocate home dialysis costs properly. We suggest that ProPAC consider this in determining if a separate home dialysis payment rate is justified. If special circumstances exist because Medicare is the principal payer for dialysis, then ProPAC might consider adjusting the rate for small rural facilities or for other justified circumstances. Again, HCFA is not implementing these recommendations. Rather, we are expressing our concerns and are emphasizing those factors that ProPAC should consider in its recommendations to Congress.

Comment: One commenter recommended that CCPD reimbursement should be set at levels currently reimbursed to durable medical equipment suppliers.

Response: Section 1881(b) of the Act provides two distinct methods for reimbursing CCPD. Under Method I, payment for CCPD is made at the facility's composite payment rate. Under Method II, payment for CCPD supplies and related services is limited to the amount established by section 6203(b) of Pub. L. 101-239, which is 130 percent of the median hospital payment rate. The Method II payment limit applies only to suppliers and not to dialysis facilities.

I. Cost Data Collection for Outpatient Providers (Recommendation 15)

Recommendation: A mechanism should be implemented for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers.

Response in the Proposed Rule: We have specifically chosen not to require Medicare-participating ambulatory surgical centers (ASCs) to submit annual cost reports, primarily to avoid imposing on ASCs the burden and expense that these reports engender. Some ASCs, especially the smaller facilities, would have difficulty absorbing the added expense of maintaining billing and recordkeeping systems necessary to satisfy an annual Medicare cost report requirement. Additional facility costs would, in turn, be reported to Medicare, inflating Medicare ASC payment rates and beneficiary co-payments (see Recommendation 16 below) as well as Medicare administrative costs. Therefore, we do not concur with the ProPAC recommendation that an annual cost report would be an appropriate mechanism for the systematic and comprehensive collection of data for free-standing settings.

We surveyed Medicare-participating ASCs in 1986 to collect procedure-specific cost data for use in setting ASC payment rates. Also, an ASC survey will be conducted during 1992. These surveys collect information regarding charges, costs, and volume on a procedure-specific basis. One portion of the 1992 survey will ask ASCs to identify component services of selected high-volume procedures and to report their actual costs in furnishing those services. The data reported for this "procedure costing" portion of the 1992 survey as well as the more general charge, cost, and utilization data collected from all ASCs are validated by random on-site audits of a representative sample of facilities. We have found this method of data collection to be cost effective at both the national and provider level and minimally disruptive to the industry. The increase in the number of Medicare-certified ASCs from slightly fewer than 500 in 1986 to more than 1400 in 1992 suggests that our current data collection procedures are not a significant impediment to Medicare participation by ASCs.

HCFA is currently sponsoring research to obtain facility cost data (that is, excluding physician professional service costs) on a sample of about 400 frequently found procedures in hospital outpatient departments, ambulatory surgical centers, and physicians' offices.

The research, due to HCFA in 1993, will demonstrate a methodology for collecting and analyzing these data and enable us to explore the reasons for differences in costs between types of outpatient sites. After the report is delivered, HCFA will be able to determine whether or not the data collection should be performed periodically.

Comment: ProPAC continues to recommend that ASCs be required to submit annual cost reports. Although they agree that the costs of outpatient data collection should be minimized, they believe that an annual cost report containing the minimum essential information might be less disruptive than a retrospective method that occurs at irregular intervals.

Response: We do not agree with ProPAC's recommendation that ASCs be required to submit annual cost reports. As we stated previously, to require annual cost reports of ASCs would be burdensome, expensive, and ultimately more costly to Medicare than the current system of rebasing ASC payment rates periodically, using audited survey data and making interim annual adjustments based on an inflationary measure such as the consumer price index for urban consumers (CPI-U).

J. Beneficiary Liability (Recommendation 16)

Recommendation: Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively should be limited to 20 percent of the payment amount allowed by Medicare.

Response in the Proposed Rule: We recognize ProPAC's concern. We have been reviewing this issue in the context of our development of a comprehensive prospective payment system for all hospital outpatient services. We are working to develop an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

Comment: In its comments, ProPAC reiterated the proposal that a beneficiary's liability for hospital outpatient services should be based on 20 percent of the payment amount allowed by Medicare, rather than on 20 percent of charges.

Response: At this time, such a methodology cannot be applied with sufficient accuracy to that majority of hospital outpatient services that are paid on a full or partial cost basis. Costs for these individual services are not known at time of delivery. Rather, Medicare payment for these services depends on retroactive settlement of the hospital's cost report and is determined

in the aggregate, based on the type of service (that is, radiology services, ASC-approved surgeries), not on the individual service. Only charges are determined for each patient and are known when the patient is billed.

We are in the process of developing a prospective payment system that will supersede the current cost-based system. In this context, we are reviewing the issue of beneficiary liability. As we stated in our comments on this recommendation, we are working to come up with an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

K. Revision of the Classification System Used to Group Ambulatory Surgery Cases (Recommendation 19)

Recommendation: The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and free-standing ambulatory surgical centers (ASCs) should be used to establish the payment groups.

Response in the Proposed Rule: In compliance with section 1833(i)(2)(A) of the Act, the current ASC payment classification system groups Medicare covered Physicians' Current Procedural Terminology (CPT) codes so as to assure that the standard overhead payment amount established for the procedures in each group takes into account the costs incurred by ASCs generally in providing services furnished in connection with the performance of those procedures.

Absent a complete revision of those sections of the Act that provide for the ASC benefit under Medicare, Part B, combining hospital data with free standing ASC data to establish a classification system for payments to ASCs would not be in compliance with the law.

Comment: ProPAC asserted that at the time the ASC patient groups were developed, cost data were not available for a number of ASC-approved services, and that the original ASC data were from a limited selection of 90 ASC sites. ProPAC also reiterated that combining hospital cost data with ASC data would result in a more accurate classification system. They believed that such an approach would not need to violate the statutory requirement that the average standard overhead payment amount established for the procedure in each group take into account the costs incurred by ASCs generally.

Response: ProPAC's concern about previous inaccuracies in payment group classifications of ASC procedures should be alleviated by the expanded

scope and depth of data being collected through the Medicare Ambulatory Surgical Center Payment Rate Survey 1992 (Form HCFA-452).

We agree with ProPAC that there might be merit in ranking ASC procedures by their cost in a hospital outpatient setting to determine each procedure's position relative to other procedures, and then to compare that scale with a parallel ranking by cost when the same procedures are performed in an ASC. However, we reiterate our initial position with respect to ProPAC's recommendation that hospital cost data be combined with ASC data to produce a more accurate classification system. To add hospital cost data to ASC cost data for the purpose of determining ASC facility payment classifications would not be in compliance with section 1833(i)(2)(A) of the Act, as stated in our response in the proposed rule. In addition, we believe that an approach such as that proposed by the Commission could significantly inflate Medicare costs.

L. Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services (Recommendation 21)

Recommendation: ProPAC believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

Response in the Proposed Rule: We currently do not have access to the necessary data to implement this recommendation. For example, hospitals would have to maintain records that would provide a breakdown of salaries and personnel hours attributable to inpatient and outpatient services. We are concerned that any future requirement for collecting the necessary data might place an undue administrative burden on hospitals. However, we encourage comments from hospitals with respect to how burdensome it would be to maintain such detail.

We would welcome comments from hospitals on this recommendation, particularly with regard to the scope and effects of the additional collection that would be required to carry out this recommendation.

Comment: ProPAC, in its comments, restated the recommendation that

national prospective payment rates for ASC-approved ambulatory surgery and radiology services be adjusted to reflect differences in labor costs. More specifically, ProPAC suggested that the appropriate labor share of the hospital outpatient setting be taken into account, and that we study whether an outpatient specific wage index is necessary.

Response: We believe that we would be able to determine a reasonably accurate representation of the labor share of hospital outpatient services. However, we do not now have access to the data required to develop an outpatient-specific wage index. We have already commented on our belief that requiring the collection of such data might place an undue administrative burden on hospitals. One commenter, representing a number of hospitals, responded to the proposed rule by voicing the concern that "ProPAC's recommendation for further study of payment adjustments for hospital-provided ASC and radiology services would result in an unreasonable data collection burden on hospitals."

The commenter pointed out that hospitals would have to maintain records that would provide a breakdown of salaries and personnel hours attributable to inpatient and outpatient services. Unless a hospital maintains completely separate inpatient and outpatient surgery and radiology areas, this would be virtually impossible. In addition, ASC procedures are not limited to just an operating room area but can occur in other ancillary departments such as emergency rooms. Also, because of observation status, it is often difficult for a hospital to know whether it is treating an inpatient or an outpatient.

M. Nursing Facility Wage Index (Recommendation 22)

Recommendation: The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

Response in the Proposed Rule: ProPAC simulated a nursing facility wage index with limited data and found significant differences from the hospital wage index. However, ProPAC indicates that these differences could be due to differences in State regulations that affect nursing homes. The differences in State regulations should be minimized drastically with the implementation of the nursing home reform provisions of

the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), effective October 1, 1990, which made the certification requirements for SNFs virtually identical for both Medicare and Medicaid.

ProPAC states that another potential reason for the failure of the hospital wage index to reflect adequately the variation in SNF wages is the skill-mix differences between hospital and nursing facility personnel. We agree that there may be a skill-mix difference between hospitals and skilled nursing facilities. We do not know whether the differences in the skill mix would result in a different wage index.

ProPAC also notes that the current system contributes to inequitable Medicare SNF payments across regions. For example, almost half of the facilities in New England and almost a third of those in the Mid-Atlantic region receive less than 85 percent of their costs. This compares with an average of only 15 percent of the facilities in other regions. We believe, however, that factors other than the current wage index are responsible for the higher than average costs being reported for the facilities in New England and the Mid-Atlantic States. Among these factors are the nursing shortage and the fact that some of those States pay for SNF services under Medicaid using a prospective case-mix system, which encourages facilities to admit higher cost, resource-intensive patients.

Furthermore, based on our experience with similar attempts to mandate the establishment of a home health agency (HHA) based wage index for determining HHA cost limits, we believe it advisable to continue using the hospital wage index for SNFs until the SNF payment system is totally revised through legislation.

Comment: ProPAC disagreed with the Secretary's decision to postpone the collection of data on SNF wages and the development of a SNF wage index until after the payment system is revised through legislation. They asserted that some of the differences between the hospital wage index and a SNF wage index might be eliminated through more uniform staffing requirements, which were mandated under sections 4201(b)(1) and 4211(b) of Pub. L. 100-203, and are currently being implemented. They acknowledged that because States may exceed Federal requirements, variation in staffing patterns across States is not likely to be completely eliminated. They stated that a SNF wage index would more appropriately reflect the impact of possible nursing shortages in nursing facilities. ProPAC indicated

that it would be advisable to collect the appropriate wage data at this time.

Response: As previously indicated, we have no way of knowing what impact a SNF wage index would have on individual SNFs. Moreover, our prior attempt to develop a wage index for HHAs proved troublesome.

When we implemented the first HHA wage index based on data received from HHAs, we received many industry complaints concerning the burdensome requirements and the accuracy of the data. As a result, Congress passed legislation that repealed the mandate for the Secretary to develop the HHA wage index. Instead, section 4027(d) of Public Law 101-508 required the hospital wage index to be used for HHAs. This legislation had a retroactive effective date, so HCFA was required to issue new cost limits using the hospital wage index for a retroactive period and all future periods. As with HHAs, we believe SNFs will have difficulty maintaining the data needed for HCFA to develop an accurate SNF wage index.

ProPAC believes a SNF wage index would more appropriately reflect the impact of possible nursing shortages in nursing facilities. We believe a nursing shortage would impact all classes of providers including hospitals, as well as SNFs. Therefore, we believe the hospital wage index also would reflect a nursing shortage.

In summary, based on the uncertain impact a SNF wage index would have on individual SNFs and on program experience in the context of HHAs, we believe it would be inappropriate to develop a SNF wage index at this time. Instead, we believe it is advisable to continue using the hospital wage index for SNFs until the SNF payment system is totally revised through legislation.

IX. Paperwork Reduction Act

Sections 412.230 and 412.273 contain information collection requirements that are subject to Office of Management and Budget (OMB) review under the Paperwork Reduction Act. Section 412.230 has been approved by OMB through October 1993 under OMB control number 0938-0573. Section 412.273 contains a new requirement whereby a hospital may request the Administrator to review a denial. Burden associated with this collection of information is estimated to be 1 hour per respondent. A notice will be published in the *Federal Register* when approval is obtained.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B—MEDICARE PROGRAMS

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

I. Part 412 is amended as follows:

A. The authority citation for part 412 continues to read as follows:

Authority: Sections 1102, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

Subpart A—General Provisions

B. Subpart A is amended as follows:

1. Section 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers and direct costs of medical education) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep

the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(b) *Summary of content.* This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems, and sets forth the general basis of these systems. Subpart B of this part sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification. Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems. Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined. Subpart E describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first four years of the prospective payment system. Subpart F sets forth the methodology for determining additional payments for outlier cases. Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system for inpatient operating costs. Subpart K describes how the prospective payment system for inpatient operating costs is implemented for hospitals located in Puerto Rico. Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation. Subpart M describes how the prospective payment system for inpatient capital-related costs is implemented effective with cost reporting periods beginning on or after October 1, 1991.

2. Section 412.2 is amended as follows:

a. Paragraphs (a), (b)(1), and the introductory text of paragraph (b)(2) are revised;

b. Paragraphs (d) and (e) are redesignated as paragraphs (e) and (f), and a new paragraph (d) is added;

c. The introductory text of newly redesignated paragraph (e) and newly redesignated paragraphs (e)(1) and (e)(2) are revised;

d. The introductory text of newly redesignated paragraph (f) and newly

redesignated paragraphs (f)(2), (f)(3), and (f)(6) are revised;

e. Newly redesignated paragraph (f)(7) is redesignated as paragraph (f)(8), and a new paragraph (f)(7) is added.

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates for inpatient operating costs and inpatient capital-related costs, hospitals receive payments for the following:

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in § 413.86 of this chapter.

§ 412.4 [Amended]

3. In § 412.4, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; and in paragraph (d)(1), the term "prospective payment rate" is changed to read "prospective payment rates", and the phrase "subparts D and E" is revised to read "subparts D, E, and M" wherever it appears.

4. Section 412.6 is revised to read as follows:

§ 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective

payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* HCFA recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

5. Section 412.8 is revised to read as follows:

§ 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates—(1) For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the *Federal Register* on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the *Federal Register* on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) For cost reporting periods beginning after September 30, 1984, HCFA publishes an annual document setting forth the methodology and data used, including the percentage increase factor, to determine prospective payment rates for inpatient operating costs and (for cost reporting periods beginning after September 30, 1991) for inpatient capital-related costs applicable to discharges occurring during the Federal fiscal year beginning on or after October 1 of that year.

(2) HCFA proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a *Federal Register* document published for public comment not later than the May 1 before the beginning of the Federal fiscal year in

which the proposed changes would apply.

(3) HCFA publishes a *Federal Register* document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

§ 412.10 [Amended]

6. In § 412.10(a), the phrase "DRG changes will be effective" is revised to read "DRG changes are effective".

C. Subpart B is amended as follows:

1. The heading of subpart B is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 [Amended]

2. In § 412.20, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears. In § 412.20(b)(1), remove the phrase ", and § 412.32" and add the word "and" before "§ 412.29".

3. In § 412.22, in paragraph (a), the phrase "A hospital will be excluded from the prospective payment system" is revised to read "A hospital is excluded from the prospective payment systems"; in paragraph (b), the phrase "will be subject to the ceiling" is revised to read "are subject to the ceiling" and the phrase "and § 412.32" is removed; and a new paragraph (d) is added to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

4. In § 412.23, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; paragraph (b)(8) is revised; and paragraph (c) is removed and reserved, to read as follows:

§ 412.23 Excluded hospitals: Classifications.

(b) * * *

(8) A hospital that seeks exclusion as a rehabilitation hospital for the first full

12-month cost reporting period that occurs after it becomes a Medicare participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated such a population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

5. In § 412.25, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; the introductory text of paragraph (a) is revised; a new paragraph (a)(13) is added; in paragraph (b), the phrase "will remain the same" is revised to read "remains the same"; and a new paragraph (c) is added, to read as follows:

§ 412.25 Excluded distinct part hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment system, a distinct part psychiatric or rehabilitation unit must meet the following requirements.

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

(c) *Changes in the status of hospital units.* For purposes of exclusion from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of a unit are made only at the start of a cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of the hospital's next cost reporting period.

§ 412.27 [Amended]

6. In the introductory text of § 412.27, the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.29 [Amended]

7. In the introductory text of § 412.29, the term "prospective payment system" is revised to read "prospective payment systems".

8. In § 412.30, paragraph (a) is revised and, in paragraph (c), the term "prospective payment system" is revised to read "prospective payment systems", to read as follows:

§ 412.30 Exclusion of new distinct part rehabilitation units and expansion of units already excluded.

(a) *New units.* (1) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent 12-month cost reporting period.

(2) If a hospital that is currently participating in Medicare has not previously sought exclusion for any rehabilitation unit and has obtained approval for added bed capacity under State licensure and under its Medicare certification, it may identify the new beds as a new rehabilitation unit for the first full 12-month cost reporting period during which the beds are used to furnish inpatient care. A unit of a currently participating hospital that includes some beds that were previously licensed and certified and some new beds is recognized as a new rehabilitation unit only if more than one-half of the beds are new.

(3) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital. The written certification described in paragraph (a)(1) of this section also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(4) For purposes of paragraph (a) of this section, a hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

§ 412.32 [Removed]

9. Section 412.32 is removed.

D. Subpart C is amended as follows:

1. The heading for subpart C is revised to read as follows:

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs**§ 412.40 [Amended]**

2. In § 412.40(a), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.42 [Amended]

3. In § 412.42, the term "prospective payment system" is revised to read "prospective payment systems" in paragraph (a) and in the introductory text of paragraph (b).

§ 412.46 [Amended]

4. In § 412.46, in paragraph (d)(1), the phrase "The PRO will review" is revised to read "The PRO reviews"; in paragraph (e)(1), the phrase "the Medicare claim will be appropriately changed" is revised to read "the Medicare claim is appropriately changed"; and in paragraph (e)(2), the phrase "the PRO will change the coding and assign the appropriate DRG" is revised to read "the PRO changes the coding and assigns the appropriate DRG".

§ 412.48 [Amended]

5. In § 412.48(c), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.50 [Amended]

6. In § 412.50(a), the phrase "The applicable payments made under the prospective payment system, as described in subpart H" is revised to read "The applicable payments made under the prospective payment systems, as described in subparts H and M".

§ 412.52 [Amended]

7. In § 412.52, the term "prospective payment system" is revised to read "prospective payment systems".

E. Subpart D is amended as follows:

1. The heading for Subpart D is revised to read as follows:

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs**§ 412.60 [Amended]**

2. Section 412.60 is amended as follows:

a. In paragraphs (a) and (c) introductory text, the phrase "HCFA will establish" is revised to read "HCFA establishes";

b. In paragraph (b), the phrase "HCFA will assign" is revised to read "HCFA assigns";

c. In paragraph (c)(1), the phrase "The classification of a particular discharge will, as appropriate, be based" is revised to read "The classification of a particular discharge is based, as appropriate."; in paragraphs (c)(2) and (c)(3), the phrase "will be" is revised to read "is"; and in paragraph (c)(3), the phrase "will provide" is revised to read "provides".

3. Section 412.62 is amended as follows:

a. The section heading and paragraph (a) are revised;

b. The heading in paragraph (b) is revised and the phrase "HCFA will determine" is revised to read "HCFA determines";

c. In the introductory text, in paragraph (c), the phrase "HCFA will update" is revised to read "HCFA updates";

d. In the introductory text, in paragraph (d), the phrase "HCFA will standardize" is revised to read "HCFA standardizes";

e. In the introductory text, in paragraph (e), the phrase "HCFA will compute" is revised to read "HCFA computes";

f. The heading and introductory text of paragraph (j) are revised.

§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.

(a) *General rule.* HCFA determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.*

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and in each region.* For each discharge classified within a DRG, HCFA establishes a national prospective payment rate for inpatient operating costs and a regional prospective

payment rate for inpatient operating costs for each region, as follows:

4. Section 412.63 is amended by revising the section heading, paragraph (a)(1), the introductory text of paragraph (o) and paragraph (p)(1); by revising in paragraph (a)(2) the phrase "Each such rate will be" to read "Each such rate is"; by revising in paragraph (b)(2)(ii) the phrase "will receive the lower" to read "receives the lower"; and by revising in paragraph (n)(1) the phrase "HCFA will adjust" to read "HCFA adjusts", to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(o) *Computing Federal rates for inpatient operating costs for large urban, other urban, and rural hospitals.* For each discharge classified within a DRG, HCFA establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

(p) *Adjusting for different area wage levels.* (1) HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs.

F. Subpart E is amended as follows:

1. The heading for Subpart E is revised to read as follows:

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

2. Section 412.70 is revised to read as follows:

§ 412.70 General description.

For discharges occurring on or after April 1, 1988 and before October 1, 1993, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

3. Section 412.71 is amended by revising the section heading; by revising paragraph (c)(1) introductory text; by revising the phrase "will decide" to read "decides" in paragraph (c)(2); and by revising the phrase "will use" to read "uses" in paragraph (d), to read as follows:

§ 412.71 Determination of base-year inpatient operating costs.

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

§ 412.73 [Amended]

4. In § 412.73, paragraph (d)(1) is amended by revising the phrase "HCFA will adjust" to read "HCFA adjusts" and by revising the phrase "will be based on a factor" to read "is based on a factor"; in paragraph (d)(2), by revising the phrase "HCFA will adjust" to read "HCFA adjusts"; and in paragraph (e) by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied".

§ 412.74 [Removed]

5. Section 412.74 is removed.

6. Section 412.75 is amended by revising the section heading; in paragraph (b), by revising the phrase "considered to be a discharge" to read "considered to be a discharge" and by combining the concluding paragraph with paragraph (b); and in paragraph (e), by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied", to read as follows:

§ 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.

§ 412.76 [Amended]

6. Section 412.76 is amended by revising the phrase "costs will be adjusted" to read "costs are adjusted" and by revising the phrase "HCFA will recover" to read "HCFA recovers".

G. Subpart F is amended as follows:

1. In § 412.80, the introductory text of paragraph (a)(1)(ii) is republished; paragraphs (a)(1)(ii)(A) and (c) are revised; and in paragraph (a)(2), the phrase "HCFA will provide cost outlier payments" is revised to read "HCFA provides cost outlier payments", to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) * * * (ii) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a cost-to-charge ratio as described in § 412.84(h), exceed the greater of the following:

(A) A fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA.

(c) *Relation to hospitals that incur indirect costs for graduate medical education programs and that serve a disproportionate share of low-income patients.* The outlier payment amounts are included in total DRG revenue for purposes of determining payments to hospitals that incur indirect costs for graduate medical education programs under § 412.105 and to hospitals that serve a disproportionate share of low-income patients under § 412.106.

2. In § 412.82, paragraph (c) is revised; paragraph (d) is removed; and paragraph (e) is redesignated as paragraph (d), to read as follows:

§ 412.82 Payment for extended length-of-stay cases (day outliers).

(c) Except as provided in § 412.86, the per diem payment made under paragraph (a) of this section is derived by taking 55 percent of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under subpart D by the arithmetic mean length-of-stay for that DRG.

§ 412.84 [Amended]

3. In § 412.84(d), the phrase "through this review will be denied" is revised to read "through this review are denied" and the phrase "these services will be recovered" is revised to read "these services are recovered".

H. Subpart G is amended as follows:

1. The heading of subpart G is revised to read as follows:

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

2. Section 412.90 is revised to read as follows:

§ 412.90 General rules.

(a) *Sole community hospitals.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) *Christian Science Sanatoria.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital is a Christian Science sanatorium. Such a sanatorium's prospective payment rates are determined in accordance with § 412.98.

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in § 412.100.

(e) *Hospitals that are located in urban areas and that are reclassified as rural.* HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals reclassified as rural, as defined in § 412.62(f). The criteria for this adjustment are set forth in § 412.102.

(f) *Hospitals that have a high percentage of ESRD beneficiary*

discharges. HCFA makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hospitals that incur indirect costs for graduate medical education programs.* HCFA makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, HCFA makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital. Criteria for identifying these hospitals are set forth in § 412.108.

3. In § 412.92, in paragraphs (b)(1)(iv) and (b)(1)(v), the phrase "will review" is revised to read "reviews"; in paragraph (b)(3), the phrase "will remain" is revised to read "remains"; in paragraph (b)(5), the phrase "will be" is revised to read "is"; and the heading of paragraph (d), and paragraphs (e)(3) introductory text and (e)(3)(i)(B) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.*

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.*

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating

costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) * * *

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

4. In § 412.96, the reference "§ 412.118(b)" in paragraph (b)(1) introductory text is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (c)(1)(ii) is revised to read "§ 412.105"; and paragraph (d) is revised to read as follows:

§ 412.96 Special treatment: Referral centers.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with § 412.63, as adjusted by the hospital's area wage index.

5. In § 412.98, paragraphs (a) and (b) are revised to read as follows:

§ 412.98 Special treatment: Christian Science Sanatoria.

(a) *General rule.* If a Christian Science Sanatorium is not excluded from the prospective payment systems under subpart B of this part, HCFA pays, for inpatient hospital services furnished to a beneficiary by that sanatorium, a predetermined fixed amount per discharge based on the sanatorium's historical inpatient operating costs per discharge.

(b) *Prospective payment rates.* For cost reporting periods beginning on or after October 1, 1983, the sanatorium's prospective payment rate for inpatient operating costs equals the amount that would constitute the sanatorium's target amount under § 413.40(c)(4) of this chapter if the institution were subject to the rate of increase ceiling specified in § 413.40 of this chapter instead of the prospective payment systems. This amount is not adjusted for the DRG weighting factor.

6. In § 412.100, paragraph (a) is revised to read as follows:

§ 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.*

(1) HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

§ 412.102 [Amended]

7. In the introductory text of § 412.102, the phrase "rural Federal payment amount" is revised to "rural Federal payment amount for operating costs".

§ 412.104 [Amended]

8. In § 412.104, in paragraph (a), the phrase "will provide" is revised to read "provides"; in the introductory text of paragraph (b) and in paragraph (b)(4) the phrase "will be" is revised to read "is"; and in paragraph (b)(5), the phrase "will be equal to" is revised to read "equals".

9. In § 412.105, the section heading and the introductory text to the section are revised; the introductory text of paragraph (a) is reprinted; and paragraphs (a)(2) and (e) are revised, to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

HCFA makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

(2) The hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, including outlier payments for inpatient operating costs determined under subpart F of this part, but excluding additional payments made under the provisions of this subpart.

(e) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

10. In § 412.106, paragraphs (a)(2) and (d)(1) are revised; the reference "§ 412.118(b)" in paragraph (a)(1)(i) is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (a)(2)(ii) is revised to read "§ 412.105"; and in paragraphs (d)(2)(i)(B) (1) and (2) the date "January 1, 1993" is revised to read "October 1, 1993", to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.* * * *

(2) The payment adjustment is applied to the hospital's total DRG revenues for inpatient operating costs.

(i) A hospital's total DRG revenues for inpatient operating costs are determined on the basis of DRG-adjusted prospective payment rates for inpatient operating costs or, for transition period payments under subpart B of this part, on the basis of the Federal portion of the hospital's payment rates.

(ii) For purposes of this section, total DRG revenues for inpatient operating costs include outlier payments for inpatient operating costs under subpart F of this part, but exclude additional payments made under this subpart.

(d) *Payment adjustment—(1) Method of adjustment.* If a hospital serves a disproportionate number of low-income patients, its total DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

10. In § 412.108, paragraphs (c) introductory text and (d)(3) introductory text are revised; in paragraph (a)(1)(i) the reference "§ 412.118(b)" is revised to read "§ 412.105(b)"; and in paragraph (d)(3)(i)(B) the term "reimbursed" is revised to read "paid" to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs based on whichever of

the following amounts yields the greatest aggregate payment for the cost reporting period:

(d) *Additional payments to hospitals experiencing a significant volume decrease.*

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

1. Subpart H is amended as follows:

1. The heading of subpart H is revised to read as follows:

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

§ 412.110 [Amended]

2. In § 412.110, the phrase "prospective payment system" is revised to read "prospective payment systems".

3. In § 412.112, the introductory text of the section and paragraph (a) are revised to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

4. In § 412.113, paragraph (a)(2)(i) introductory text is republished and paragraph (a)(2)(i)(E) is revised to read as follows:

§ 412.113 Other payments.

(a) *Capital-related costs.* * * *

(2) *Reduction to capital-related payments.* (i) Except for sole community hospitals as defined in § 412.92, the amount of capital-related payments for cost reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under

§ 413.157 of this chapter) is reduced by—

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

§ 412.115 [Amended]

5. In § 412.115, in paragraph (a), the phrase "An additional payment will be made" is revised to read "An additional payment is made".

§ 412.120 [Amended]

6. In § 412.120 in paragraph (a), the phrase "payments otherwise payable to a hospital will be reduced" is revised to read "payments otherwise payable to a hospital are reduced"; and in the introductory text of paragraph (b) the phrase "the Medicare payment will be determined" is revised to read "the Medicare payment is determined".

7. In § 412.130, in paragraphs (b)(1) and (b)(2), the phrase "prospective payment system" is revised to read "prospective payment system".

J. Subpart K is amended as follows:

1. The heading of subpart K is revised to read as follows:

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

2. Section 412.200 is revised to read as follows:

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of subparts D and E, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for these hospitals is set forth in §§ 412.204 through 412.212.

3. Section 412.204 is revised to read as follows:

§ 412.204 Payments to hospitals located in Puerto Rico.

Payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(a) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(b) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

4. In § 412.208, paragraphs (a) and (b), and the heading of paragraph (h) are revised to read as follows:

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* HCFA determines the Puerto Rico adjusted DRG prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system for inpatient operating costs, HCFA determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(h) *Computing Puerto Rico rates established under the prospective payment system for inpatient operating costs for urban and rural hospitals.*

§ 412.210 [Amended]

5. In § 412.210, in paragraphs (a)(1), (b)(3) and the introductory text of paragraphs (d), the phrase, "for inpatient operating costs" is added after the phrase "prospective payment rate".

§ 412.212 [Amended]

6. In § 412.212, paragraph (a), the phrase "national prospective payment rate" is revised to read "national prospective payment rate for inpatient operating costs".

§ 412.220 [Amended]

7. In § 412.220, introductory text for the section, the phrase "prospective payment system." is revised to read "prospective payment system for inpatient operating costs."

Subpart L—The Medicare Geographic Classification Review Board

L. Subpart L is amended as follows:
1. Section 412.230 is amended as follows:

- a. The heading is revised;
- b. Paragraphs (a)(1), (a)(3) and (a)(4) introductory text and (a)(4)(iii) are revised;
- c. New paragraphs (a)(4)(v) and (a)(5) are added;
- d. In the heading of paragraph (d) and in paragraphs (d)(1) and (d)(3) introductory text, the phrase "standardized amount" is revised to read "standardized amount for inpatient operating costs";
- e. In paragraph (d)(3)(ii), the phrase "prospective payment system rates for inpatient hospital services" is revised to read "prospective payment rates for inpatient operating costs";
- f. Paragraph (e)(1) is revised;
- g. Paragraph (e)(2) introductory text is republished and paragraph (e)(2)(i) is revised;
- h. Paragraph (e)(2)(ii) introductory text and paragraph (e)(2)(ii)(A) are revised.

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General—(1) Purpose.* An individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, wage index value, or both. An individual hospital may not be redesignated to more than one area.

(3) *Proximity.* Except as provided in paragraph (a)(4) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the adjacent area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

(4) *Special rules for sole community hospitals and rural referral centers.* To be redesignated under the special rules in this paragraph, a hospital must be a sole community hospital or a rural referral center as of the date of the MGCRB's review.

(iii) If a hospital that is a rural referral center, a sole community hospital, or both qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. If the hospital is closer to another rural area than to any

urban area, it may seek redesignation to either the closest rural or the closest urban area.

(v) A hospital that is redesignated under paragraph (a)(4) of this section may not be redesignated in the same fiscal year under paragraph (a)(2) or (a)(3) of this section.

(5) *Application of criteria.* In applying the numeric criteria contained in §§ 412.230(b)(1) and (2), (d)(2), (e)(1)(iii), and (e)(1)(iv) (A) and (B), rounding of numbers to meet the mileage or qualifying percentage standard is not permitted.

(e) *Use of urban or other rural area's wage index—*

(1) *Criteria for use of adjacent area's wage index.* To use an adjacent area's wage index, a hospital must demonstrate the following:

(i) The hospital's incurred wage costs are comparable to hospital wage costs in an adjacent urban or other rural area;

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section;

(iii) The hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; and

(iv) One of the following conditions apply:

(A) The hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation; or

(B) The hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation.

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate data as follows:

(i) For hospital-specific data, the hospital must provide data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(ii) For data of other hospitals, the hospital must provide data concerning the following:

(A) The average hourly wage in the area in which the hospital is located and the average hourly wage in the adjacent area. The wage data are taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during

the fiscal year prior to the fiscal year for which the hospital requests reclassification and;

4. In § 412.232, paragraph (c) is revised; paragraphs (d)(2) introductory text and (d)(2)(ii) introductory text are republished; and paragraphs (d)(2)(i) and (d)(2)(ii)(A) are revised, to read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

(c) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

(d) * * *

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For hospital-specific data, the hospitals must provide data from the HCFA wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(ii) For data for other hospitals, the hospitals must provide the following:

(A) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

5. In § 412.234, paragraph (b) is revised, and in the heading of paragraph (c) the phrase "inpatient operating costs" is added after the phrase "standardized amount", to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(b) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

6. In § 412.273, the introductory text of paragraph (a), paragraph (a)(1) and paragraph (b) are revised; and paragraph (c) is added, to read as follows:

§ 412.273 Withdrawing an application.

(a) *Timing of a withdrawal.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application if the request for withdrawal is submitted to the MGCRB during the following time periods:

(1) At any time before the MGCRB issues a decision on the application; or

(b) *Written request only.* A request to withdraw an application must be made in writing to the MGCRB by all hospitals that are party to the application.

(c) *Appeal of the MGCRB's denial of a hospital's request for withdrawal.* (1) A hospital may file an appeal of the MGCRB's denial of its request for withdrawal of an application to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

(3) In § 412.278, a heading is added to paragraph (f) and paragraphs (f)(1) and (f)(3) are revised; and a new paragraph (g) is added to read as follows:

§ 412.278 Administrator's review.

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

(3) The Administrator's decision issued under § 412.278 (a) or (c) is the final Departmental decision, unless it is amended under § 412.278(g). The final Departmental decision is not subject to judicial review.

(g) *Amendment of Administrator decision—(1) Hospital's request for amendment.* The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to HCFA.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her

discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

M. Subpart M is amended as follows:

1. In § 412.300, paragraph (b) is revised to read as follows:

§ 412.300 Scope of subpart and definition.

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years. The following hospitals are not new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

2. In § 412.302, the introductory text of paragraph (b) is revised; paragraphs (b)(3)(iii) and (b)(7) are added; paragraphs (c)(1)(ii), (c)(1)(iv), (c)(1)(v), (c)(1)(vi)(B) are revised; the introductory text of paragraph (c)(2)(i) is republished; and paragraph (c)(2)(i)(B) is revised, to read as follows:

§ 412.302 Introduction to capital costs.

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in § 412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under

§ 412.328(a)(2). Old capital costs include the following:

(3) * * *

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were recognized under this subpart, whichever is later.

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpatient hospital care on December 31, 1990 and the costs meet all other provisions for recognition of old capital costs contained in this section.

(c) *Obligated capital costs—(1) General rule.* * * *

(ii) *Moveable equipment.* Moveable equipment is recognized as old capital only if all of the conditions specified in paragraphs (c)(1)(i) (B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment; the item of equipment costs at least \$100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

(iv) *Extension of deadline.* HCFA may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a

construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or 180 days after the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to HCFA within 60 days. Within 90 days, HCFA notifies the intermediary of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) *Notification to intermediary.* The hospital must submit to its intermediary the binding agreement and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992 or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991.

(vii) *Determining old capital costs.*

(B) The intermediary advises the hospital of its determination by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

(2) *Lengthy certificate-of-need process.* (i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

3. In § 412.328, paragraph (a)(3) is added; paragraphs (b)(2), (b)(3), (c)(1), (f)(1)(i), and (f)(1)(iii) are revised; the introductory text of paragraph (f)(3) is republished; paragraph (f)(4) is redesignated as paragraph (f)(5); and a new paragraph (f)(4) is added, to read as follows:

§ 412.328 Determining and updating the hospital-specific rate.

(a) Base-year cost reporting period.

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital-specific rate is based on the hospital's old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) Base-year costs per discharge.

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge, a discharge includes discharges as defined in § 412.4(a) and transfers as defined in § 412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. HCFA divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, HCFA adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, HCFA determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of HCFA as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of

the date of the final determination of the hospital-specific rate.

(c) *Case-mix adjustment*—(1) *Determining transfer-adjusted case mix value.* Step 1: For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as of June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, HCFA determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. HCFA or the intermediary, as appropriate, multiplies the DRG weight for each case by one of the following factors:

(f) *Redetermination of hospital-specific rate*—(1) *General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs are excluded from the redetermination of the hospital-specific rate.

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period, whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the hospital's current hospital-specific rate.

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

(4) *Denial by intermediary.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital that its request is denied and explains the basis for the denial.

4. A new § 412.331 is added to read as follows:

§ 412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under § 413.134(k) of this chapter, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. The following rules apply to the revised hospital-specific rate and payment determination:

(1) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge weighted hospital-specific rate.

(2) *Payment determination.* The discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate to establish the appropriate payment methodology under § 412.336 and for payment purposes under §§ 412.340 or 412.344. The revised payment methodology is effective as of the date of merger or consolidation.

(3) *Old capital cost determination.* The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

(b) *Hospital dissolution.* If a hospital separates into two or more hospitals that are subject to capital payments under this subpart after the base year, the intermediary determines new hospital-specific rates for each separate hospital under the provisions of § 412.328 effective as of the date of the dissolution. The new hospital-specific rates are determined as follows:

(1) *Hospital-specific rate*—(i) *Adequate base year data.* The intermediary determines whether the base year capital-related cost data and necessary statistical records are

adequate to reconstruct the cost and other data required under § 412.328 from the former hospital's financial records to determine the hospital-specific rates for each facility. If the data are adequate, the intermediary uses the former hospital's base period to determine the hospital-specific rate for each separate hospital.

(ii) *Inadequate original base year data.* If the intermediary determines that the base period data for the former hospital is inadequate to establish separate hospital-specific rates, the intermediary establishes a new base period for each hospital. The new base period is each hospital's first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) immediately following separation of the hospitals. The intermediary determines the hospital-specific rate for each hospital using the new base period under § 412.328.

(2) *Payment determinations.* The intermediary applies the payment methodology provisions of § 412.336. The revised payment determination is effective as of the date of the hospital's dissolution.

(3) *Old capital cost determination.* In determining the old capital costs for each hospital, the amount recognized as old capital is limited to the allowable capital-related costs attributable to assets that were in use for patient care as of December 31, 1990, and the hospitals are subject to all other transition period rules of this subpart.

5. Section 412.348(e)(2) is revised to read as follows:

§ 412.348 Exception payments during transition period.

(e) * * *

(2) A hospital must apply to its HCFA Regional Office by the later of October 1, 1992 or 180 days after the extraordinary circumstance causing the unanticipated expenditures for a determination by the HCFA Administrator of whether the hospital is eligible for an additional payment based on the nature of the circumstances and the amount of financial loss documented by the hospital.

PART 413—[AMENDED]

II. Part 413 is amended as follows:

A. The authority citation for part 413 continues to read as follows:

Authority: Sections 1102, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), (i), and (n),

1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Pub. L. 100-360 as amended by sec. 608(d)(3) of Pub. L. 100-485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 101-234 (42 U.S.C. 1395ww (note)).

Subpart A—Introduction and General Rules

B. Subpart A is amended as follows:

1. In § 413.1, paragraph (d)(2) introductory text and paragraph (d)(2)(i) are revised to read as follows:

§ 413.1 Introduction.

(d) *Payment for inpatient hospital services.*

(2) Payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of hospital inpatient services for cost reporting periods beginning on or after October 1, 1983, and for the capital-related costs of inpatient services for cost reporting periods beginning on or after October 1, 1991, are determined prospectively on a per discharge basis under part 412 of this chapter except as follows:

(i) Payment for capital-related costs for cost reporting periods beginning before October 1, 1991, medical education costs, kidney acquisition costs, and the costs of certain anesthesia services, is described in § 412.113 of this chapter.

2. In § 413.5, the introductory text of paragraph (c) is revised to read as follows:

§ 413.5 Cost reimbursement: General

(c) As formulated herein, the principles given recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital (in the case of certain proprietary providers). With respect to allowable costs some items of inclusion and exclusion are:

Subpart B—Accounting Records and Reports

C. Subpart B is amended as follows:

§ 413.24 [Amended]

In § 413.24(f)(3)(iii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart C—Limits on Cost Reimbursement

D. Subpart C is amended as follows:

In § 413.40, paragraph (a)(2)(i) introductory text is republished; paragraphs (a)(2)(i)(B), (c)(2), (f)(1)(i), and (g)(3)(iii) are revised; and a sentence is added at the end of paragraph (b)(1) to read as follows:

§ 413.40 Ceiling on rate of hospital cost increases.

(a) * * *

(2) *Applicability.* (i) This section is not applicable to—

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance with section 1886 (d) and (g) of the Act and part 412 of this chapter.

(b) *Cost reporting periods subject to the rate of increase ceiling—*(1) * * * when the operational structure of a hospital or distinct unit changes (that is, a freestanding hospital becomes a distinct part unit or vice versa) the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

(c) * * *

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section are determined on a per discharge basis. For purposes of this subpart, a patient is considered discharged on the earliest of the following dates:

(i) The date the patient has exhausted Medicare Part A inpatient hospital benefits (including the election to use lifetime reserve days) during his or her spell of illness.

(ii) The date the patient is formally released as specified in § 412.4(a)(1) of this chapter;

(iii) The date the patient is transferred to another facility.

(iv) The date the patient dies.

(f) *Exemptions* (1)(i) *New hospitals.* A new hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least two years after the hospital accepts its first patient. The first 12-month cost reporting period beginning at least one year after the hospital accepts its first patient is the base year in accordance with paragraph (b) of this section. For purposes of this

section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than two full years; and

(B) Has provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program, for less than two years.

(g) *Adjustments—*

(3) * * *

(iii) *Adjusting operating costs.* Without a formal request from a hospital, HCFA may adjust the amount of operating costs determined under paragraph (c)(1) of this section to take into account certain adjustments. These adjustments include, but are not limited to, adjustments under paragraphs (g)(3)(ii)(A), (B), (C), (E), and (F) of this section.

Subpart E—Payments to Providers

E. Subpart E is amended as follows:

§ 413.64 [Amended]

In § 413.64, in paragraphs (h)(1)(i) and (h)(1)(ii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart F—Specific Categories of Costs

F. Subpart F is amended as follows:

Section 413.86 is amended by adding paragraph (h)(6) to read as follows:

§ 413.86 Direct graduate medical education payments.

(h) * * *

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

Subpart G—Capital Related Costs

G. Subpart G is amended as follows:

§ 413.134 [Amended]

1. In § 413.134, in paragraph (f)(2)(iii)(D), the reference

"§ 412.340(a)(2)" is revised to read "§ 412.344(a)(2)".

§ 413.157 [Amended]

2. In § 413.157, paragraph (c)(5) is removed.

(Catalog of Federal Domestic Assistance Programs No. 93.733, Medicare—Hospital Insurance; No. 93.744, Medicare—Supplementary Medicare Insurance)

Dated: August 24, 1992.

William Toby, Jr.,

Acting Deputy Administrator, Health Care Financing Administration.

Approved: August 24, 1992.

Louis W. Sullivan,

Secretary.

[Editorial Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges on or After October 1, 1992 and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 1992

I. Summary and Background

In this addendum, we are making changes in the amounts and factors for determining prospective payment rates for Medicare inpatient hospital operating costs and Medicare inpatient hospital capital-related costs. We are also setting forth new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1992, except for sole community hospitals, Medicare-dependent for cost reporting periods ending on or before March 31, 1993 small rural hospitals, hospitals located in Puerto Rico, and hospitals subject to the regional floor, each hospital's payment per discharge under the prospective payment system will be comprised of 100 percent of the Federal national rate.

For cost reporting periods beginning on or after April 1, 1990, sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate (subject to the regional floor), the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Hospitals in Puerto Rico are paid on the basis of a rate per discharge composed of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act). Hospitals

affected by the regional floor are paid on the basis of 85 percent of the Federal national rate and 15 percent of the Federal regional rate (section 1886(d)(1)(A)(iii) of the Act).

As discussed below in section II, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, will affect the calculation of the Federal rates. In section III we discuss changes we are making in the determination of the prospective payment rates for Medicare inpatient capital-related costs. Section IV sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum in section V.

II. Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 1993

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the manner in which we are changing some of the factors used in determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1992. As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors for discharges in FY 1993.

In summary, the standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum were—

- Updated by 2.55 percent for urban hospitals (that is, the market basket percentage increase of 4.1 percent minus 1.55 percent); and 3.55 percent for rural hospitals (that is, the market basket percentage increase of 4.1 percent minus 0.55 percent);
- Adjusted by removing the FY 1992 outlier offsets and applying the revised urban and rural outlier offsets;
- Adjusted to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1992 budget neutrality factor and applying a revised factor; and
- Adjusted to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by removing the FY 1992 budget

neutrality adjustment factors and applying revised budget neutrality adjustment factors to the urban and rural standardized amounts.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(C) and (d)(9)(B)(ii) of the Act required that the updated base-year per discharge costs and, for Puerto Rico, the updated target amounts, respectively, be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Since the standardized amounts have already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, no additional adjustments for these factors for FY 1993 were made. That is, the standardization adjustments reflected in the FY 1993 standardized amounts are the same as those reflected in the FY 1992 standardized amounts.

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act require that, in making payments under the prospective

payment system, the Secretary adjust the proportion of payments that are wage-related (as estimated by the Secretary from time to time). Beginning with October 1, 1990, when the market basket was rebased, we have considered 71.40 percent of costs to be labor-related for purposes of the prospective payment system.

2. Computing Urban and Rural Averages Within Geographic Areas

Section 1886(d)(3) of the Act requires the Secretary to compute three average standardized amounts for discharges occurring in a fiscal year: One for hospitals located in rural areas; one for hospitals located in large urban areas; and one for hospitals located in other urban areas. In addition, under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and rural areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines a "large urban area" as an urban area with a population of more than 1,000,000. In addition, section 4009(i) Public Law 100-203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Under that section, urban areas that do not meet the definition of a "large urban area" are referred to as "other urban areas."

Based on 1990 population estimates published by the Bureau of the Census, the current 49 large urban areas continue to meet the criteria to be defined as large urban areas for FY 1993. These areas are identified by an asterisk in Tables 4a and 4c. No additional areas have been identified. Therefore, we are making no change in these areas for purposes of this final rule.

Table 1a contains the three national standardized amounts that continue to be applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that continue to be applicable for hospitals located in census areas subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount, the national large urban standardized amount, and the

national other urban standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. This table also includes the three standardized amounts that would be applicable to most hospitals in Puerto Rico.

The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, we will update the large urban, other urban, and rural average standardized amounts using the applicable percentage increases specified in section 1886(b)(3)(B)(i). Section 1886(b)(3)(B)(i)(VIII) of the Act (as added by sections 4002 (a) and (c) of Public Law 101-508) specifies the following update factors for the standardized amounts for FY 1993:

- The market basket percentage increase minus 1.55 percentage points (that is, 2.55 percent) for hospitals located in urban areas.

- The market basket percentage increase minus 0.55 percentage points (that is, 3.55 percent) for hospitals located in rural areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecasted hospital market basket increase for FY 1993 is 4.1 percent.

Although the update factor for FY 1993 is set by law, we were required by section 1886(e)(3)(B) of the Act to report to Congress no later than March 1, 1992 on our initial recommendation of update factors for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we published the report to Congress as Appendix C to the proposed rule. Our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix C to this final rule.

4. Other Adjustments to the Average Standardized Amounts

a. *Reclassified Hospitals—Budget Neutrality Adjustment.* Section 1886(d)(8)(B) of the Act provides that certain rural hospitals are deemed urban effective with discharges occurring on or after October 1, 1988. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals

beginning in FY 1992 based on determinations by the Medicare Geographic Classification Review Board (MGCRCB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Section 1886(d)(8)(D) of the Act specifies two budget neutrality objectives that must be met. First, the FY 1993 urban standardized amounts are to be adjusted so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8) (B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Second, the rural standardized amounts are to be adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increase nor decrease as a result of implementation of these provisions. We note that some rural referral centers have been reclassified for purposes of the standardized amount. The budget neutrality adjustment for geographic reclassifications does not include the cost of paying the rural referral centers the other urban standardized amount since they are already paid on this basis. Rather, the budget neutrality adjustment includes only the difference between the payments to these hospitals after reclassification and payments as a rural referral center before reclassification (for example, higher disproportionate share payments or the difference between large urban and other urban rates, as applicable). Once the rural referral center triennial reviews are implemented beginning October 1, 1992 (see section V.B., above), it is likely that several of these hospitals will no longer be eligible for rural referral center status. At that point, it would be appropriate to include the cost of paying the hospitals the other urban standardized amount in the budget neutrality adjustment factor. Therefore, in calculating the final FY 1993 budget neutrality adjustment factor, we have identified those hospitals that are likely to lose their rural referral center status and determined the cost of paying them the urban standardized amount for the portion of FY 1993 that we estimate they will no longer qualify as a rural referral center. We have included this cost in the budget neutrality adjustment factor. The following adjustment factors, necessary to achieve the requisite budget neutrality constraints, were applied to the proposed standardized amounts:

Urban	Rural
.987245	.999457

The following adjustment factors were applied to the final standardized amounts:

Urban	Rural
.987471	.999433

The adjustment factors are applied to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment factors. We note that the proposed FY 1993 adjustments reflected wage index and standardized amount reclassifications approved by the MGCRCB or the Administrator as of March 30, 1992. The final budget neutrality adjustment factors reflect the effects of all reclassification decisions and changes in these decisions resulting from appeals and review of the MGCRCB's decisions for FY 1993, or from a hospital's request for the withdrawal of a reclassification.

b. *Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment.* Section 1886(d)(4)(C)(iii) of the Act specifies that beginning in FY 1991, the annual DRG reclassifications and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II.C of the preamble to this final rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals, our analysis indicates that the normalization adjustment does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated based on new survey data no later than October 1, 1990 and on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement in

section 1886(d)(3)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compared aggregate payments using the FY 1992 relative weights and the wage index effective October 1, 1991 to aggregate payments using the proposed FY 1993 relative weights and wage index. The same methodology was used for the FY 1992 budget neutrality adjustment. (See the discussion in the August 30, 1991 final rule (56 FR 43246).) Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.000007. We applied this budget neutrality adjustment factor to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment.

The budget neutrality adjustment factor that was applied to the final standardized amount is .999851.

In addition, we are continuing to apply the same FY 1993 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1992, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

c. *Retroactive Budget Neutrality Adjustment to Reflect FY 1992 Midyear Wage Index Corrections.* In the September 4, 1990 final rule (55 FR 36042), we set forth under § 412.63(l) (redesignated at § 412.63(p)) our policy for making midyear corrections in the wage index and applying those corrections on a prospective basis effective with discharges occurring after the date the corrections are made. As described in that rule, when midyear corrections are made under the provisions of § 412.63(l), the correction in the wage index value for the affected area is effective prospectively from the date the revision is made; however, both the corresponding prospective adjustment to the wage index values for all other wage areas (to reflect the effect of the corrected data on the national average hourly wage), and the budget neutrality adjustment to the standardized amounts required by section 1886(d)(3)(E) of the Act (to account for the effect on payments of the midyear corrections), are not made until the beginning of the next fiscal year.

To account for the effect that mid-year corrections in the wage index for FY 1992 had on program payments for that year, we computed a retroactive budget neutrality adjustment factor of .999586 in

the proposed rule. This adjustment was computed by comparing FY 1992 aggregate payments before the wage data corrections were made with aggregate payments after the revised wage index values were implemented. Based on the additional revised wage values that have been implemented since the proposed rule was issued, the final budget neutral adjustment factor is .999490. This adjustment has been applied to the FY 1993 standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment for mid-year wage corrections.

d. *Outliers.* Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act requires that the urban and rural standardized amounts be separately reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments for hospitals located in urban areas and those located in rural areas. Section 1886(d)(9)(B)(iv) of the Act requires that the urban and rural standardized amounts be reduced by the proportion of estimated total payments made to hospitals in Puerto Rico attributable to estimated outlier payments.

Consequently, instead of a uniform reduction factor applying equally to all the standardized amounts, there are two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Furthermore, sections 1886(d)(5)(A)(iv) and 1886(d)(9)(D)(i) of the Act direct that outlier payments in any year may not be less than 5 percent nor more than 6 percent of total payments projected to be made based on the prospective payment rates.

In the August 30, 1991 final rule, we set the outlier thresholds so as to result in estimated operating outlier payments equal to 5.1 percent of total operating prospective payments. We also set the same outlier thresholds and offsets for the Puerto Rico prospective payment standardized amounts as we had for hospitals located outside Puerto Rico. For FY 1992, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 32 days or 3.0 standard deviations. The cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or \$44,000 (\$40,100 for hospitals that have not yet entered the prospective payment system for inpatient capital-related

costs). The outlier adjustments for FY 1992 that were effective for discharges on or after October 1, 1991 were .944047 for the urban rates, .979202 for the rural rates, and .949722 for the capital Federal rate.

As discussed in section V.A of the preamble to this final rule, we proposed to establish outlier thresholds that would be applicable to both inpatient operating costs and inpatient capital-related costs. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1993 were as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944828	.978085	.9490

The final outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944598	.978420	.9496

We proposed to continue to set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments. The model that we use to determine the outlier thresholds necessary to target our desired outlier payment percentage for FY 1993 uses the FY 1991 MEDPAR file and the most recent available information on hospital-specific payment parameters (such as the cost-to-charge ratios). This information is based on the June 30, 1992 update of the provider-specific file used in the PRICER program.

B. Adjustments for Area Wage Levels and Cost-of-Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section II.D of this addendum. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables Ia, Ib, and Ic, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. Adjustment for Area Wage Levels

Sections 1886(d)(2)(H) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this final rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4c of the addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related cost for these two States are taken into account in the adjustment for area wages above. For FY 1993, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table of Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska—All areas.....	1.25
Hawaii:	
Oahu.....	1.225
Kauai.....	1.175
Maui.....	1.20
Molokai.....	1.20
Lanai.....	1.20
Hawaii.....	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management)

C. DRG Weighting Factors

As discussed in section II of the preamble to this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that are intended to reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs.

Table 5 of section V of this addendum contains the weighting factors that we will use for discharges occurring in FY 1993. These factors have been recalibrated as explained in section II.C of the preamble.

D. Calculation of Prospective Payment Rates for FY 1993

General Formula for Calculation of Prospective Payment Rates for FY 1993

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent, small rural hospitals = Federal rate

Prospective payment rate for sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent, small rural hospitals = Whichever of the rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the FY 1982 hospital-specific rate, or 100 percent of the FY 1987 hospital specific rate

Prospective payment rate for Puerto Rico = 75 percent of the Puerto Rico rate + 25 percent of a discharge-weighted average of the large urban, other urban, and rural national rates

1. Federal Rate

For discharges occurring on or after October 1, 1992 and before October 1, 1993, except for sole community hospitals, Medicare-dependent, small rural hospitals (for cost reporting periods ending on or before March 31, 1993), hospitals located in Puerto Rico, and hospitals subject to the regional floor, the hospital's rate is comprised exclusively of the Federal national rate. Section 1886(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals located in census regions that have a regional rate that is higher than the national rate. The Federal rate for hospitals located in census regions that have a regional rate that is higher than the national rate equals 85 percent of the Federal national rate plus 15 percent of the Federal regional rate. For discharges occurring on or after October 1, 1992, rural hospitals in regions I, II, III, and IV and urban hospitals in regions I, IV, and VI are affected by the regional floor.

The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban, other urban, or rural (see Tables 1a and 1b, section V of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4a, 4b, and 4c, section V of this addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by

the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted if appropriate under Step 3).

Step 5—Multiply the final amount from Step 4 by the weighting factor corresponding to the appropriate DRG (see Table 5, section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals)

Section 1886(d)(5)(D)(i) of the Act provides that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate (subject to the regional floor), the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Under section 1886(d)(5)(G) of the Act, Medicare-dependent small rural hospitals are eligible for special payment under the prospective payment system for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993 using the same formula applicable to sole community hospitals.

Hospital-specific rates have been determined for each of these hospitals based on both the FY 1982 cost per discharge and the FY 1987 cost per discharge. For a more detailed discussion of the calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. *Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 1993 Cost Reporting Periods.* For cost reporting periods beginning on or after October 1, 1992, we are increasing the hospital-specific rates by 4.1 percent (the hospital market basket percentage increase) for sole community hospitals located in all areas. The update, which is effective for cost reporting periods beginning in FY 1993, is not applicable to Medicare-dependent small rural hospitals since the provision ends with cost reporting periods ending after March 31, 1993. Section 1886(b)(3)(C)(ii) of the Act (as amended by section 4002(c)(2)(A)(ii) of Pub. L. 101-508) provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(ii) of the Act, which, for cost reporting periods beginning in FY

1993, is the market basket rate of increase.

b. *Calculation of Hospital-Specific Rate.* For sole community hospital cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993, the applicable hospital-specific rate will be calculated by multiplying a hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 104.1 percent). In addition, the hospital-specific rate will be adjusted by the budget neutrality adjustment factor (that is, .999851) as discussed in section II.A.4.b of this addendum. This resulting rate will be used in determining under which rate a sole community hospital is paid for its cost reporting period beginning on or after October 1, 1992, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1992 and Before October 1, 1993

a. *Puerto Rico Rate.* The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban, other urban, or rural designation of the hospital (see Table 1c, section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section V of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 75 percent.

Step 5—Multiply the amount from Step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section V of the addendum).

b. *National Rate.* The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section V of the addendum) by the appropriate wage index.

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 25 percent.

Step 4—Multiply the amount from Step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section V of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1993

The prospective payment system for hospital inpatient capital costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospital inpatient capital-related costs are paid during a 10-year transition period extending through FY 2001 on the basis of an increasing proportion of a Federal rate for capital and a decreasing proportion of a hospital's historical costs for capital as described below.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308-412.352 of the regulations. Below we discuss the manner in which the factors used for determining the Federal rate and the hospital-specific rate are changed. The rate changes will be effective for discharges occurring on or after October 1, 1992.

The FY 1992 standard Federal payment rate for capital-related costs under the prospective payment system was computed by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per discharge. The standard Federal rate is updated each year for increases in capital-related costs as provided in § 412.308(c)(1). Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of total capital payments under the Federal rate. For FY 1992 through FY 2001, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated additional payments made for exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments after any changes resulting from the annual DRG reclassification and the recalibration of DRG weights and in the geographic adjustment factor are budget neutral. For FY 1992 through FY 1995, § 412.352 requires that the Federal rate is also adjusted by a budget neutrality factor, so that estimated aggregate payments for inpatient hospital capital costs will equal 90 percent of the estimated payments that would have been made for capital-

related costs on a reasonable cost basis during the fiscal year.

The hospital-specific rate for each hospital was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment reduction factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. The hospital-specific rate is updated each year for inflation and for changes in the exceptions payment adjustment factor and the budget neutrality adjustment factor.

To determine the appropriate budget neutrality adjustment factors and the exceptions reduction factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. The model and its application are more fully described in appendix B.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid under a special payment formula. These hospitals are paid a blended rate that takes into account their geographical designation and is comprised of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals in the prospective payment system for inpatient capital costs. Accordingly, we compute a separate Federal rate specific to Puerto Rico hospitals using the same methodology used to compute the national rate for capital costs. The Federal rate for hospitals in Puerto Rico is based on 75 percent of the Puerto Rico rate and 25 percent of the national rate.

A. Determination of the FY 1993 Federal Rate for Capital Costs.

For FY 1992, the Federal rate was \$415.59. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1993 Federal rate would be \$416.36. In this final rule, we are establishing an FY 1993 Federal rate of \$417.29.

In the discussion that follows, we explain the factors that determined the

FY 1993 Federal rate. In particular, we explain why the Federal rate has increased only 0.41 percent over FY 1992. The major factor contributing to the modest increase in the Federal rate is the requirement that estimated payments each year from FY 1992 through FY 1995 for capital costs equal 90 percent of what would have been payable that year on a reasonable cost basis. Based on the most recent data, we now estimate that capital payments for FY 1992 will equal 92.85 percent of reasonable costs. The data thus indicates that the budget neutrality adjustment for FY 1992 was not sufficient to meet the 90 percent target. As a consequence, the Federal rate for FY 1992 was higher than it should have been on the basis of the current data. While we do not retroactively adjust the budget neutrality factor and the Federal rate for previous years to account for revised estimates, we do employ the most recent information to refine the budget neutrality adjustment for subsequent years. The result is a larger budget neutrality adjustment for FY 1993, which restricts the increase in the Federal rate to 0.41 percent.

Although the Federal rate for FY 1993 is only 0.41 percent higher than the FY 1992 Federal rate, we note that Federal rate payments (holding the proportion of payment based on the Federal rate constant) will increase by 2.0 percent before any increase in the case-mix index is taken into account. More importantly, we estimate that total capital payments per case will increase 6.21 percent in FY 1993.

If FY 1992 payments had not been excessive (that is, had equalled 90 percent of what would have been payable on a reasonable cost basis), total payments would increase 9.6 percent. We explain below in section III.A.6. why the rate of increase in the Federal rate will generally be lower than the rate of increase in payments. It is important to emphasize that the increase in capital payments is a much more important factor in gauging the adequacy of payment under the capital prospective payment system than changes in the Federal rate alone.

Finally, it should be noted that total payments to hospitals under the prospective payment system will be relatively insensitive to changes in the Federal rate even after the expiration of the budget neutrality provision in FY 1996. Since capital payments constitute about 10 percent of hospital payments, a 1 percentage point change in the Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

1. Standard Federal Rate Update Factor for Inflation

Section 412.308(c)(1)(i) provides that for FY 1993 through FY 1995, the standard Federal rate is updated on the basis of a lagged 2-year moving average of actual increases in Medicare inpatient capital-related costs per discharge. The 2-year moving average is based on the actual increase, adjusted for case-mix index change, in Medicare inpatient capital-related costs per case for the fiscal years 3 and 4 years before the fiscal year in question.

We proposed that the FY 1993 update factor for the Federal rate would be 3.76 percent. In this final rule, we are providing that the final FY 1993 update factor for the Federal rate will be increased by 6.07 percent.

Comment: Several commenters argued that the proposed update factor of 3.76 percent was too low. Some of these commenters noted that the calculation of the average cost per case increases seemed to employ data from a larger set of hospitals than just prospective payment hospitals. These commenters contended that using data only from prospective payment hospitals would produce an update factor of 4.37 percent, or .61 of a percentage point higher than the proposed update factor. One commenter noted that the proposed update factor of 3.76 percent was significantly lower (2.21 percentage points) than the update factor projected at the time of the August 30, 1991 final rule implementing the capital prospective payment system (56 FR 43522).

Response: For FY 1993, the update factor is based on the increase in Medicare inpatient capital-related costs per case between FY 1988 and FY 1990. These are the most recent fiscal years for which cost report data are available. To determine the amount of the increase, we apportioned a hospital's costs and discharges to each fiscal year based on the number of days in the hospital's cost reporting period that occurred during the applicable fiscal year. Thus, an individual hospital may have more than one cost report included in the calculation.

We proposed that the FY 1993 update factor for the Federal rate would be 3.76 percent. The following chart shows how this figure was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number of hospitals	Capital cost per case ¹	Percent increase	Observed case mix increase (percent)	Adjustment to Case-mix increase (percent)
1988.....	6356	\$485.75			
1989.....	6282	518.90	6.83	2.52	
1990.....	5155	547.23	5.46	0.85	1.22

FY	Adjusted case mix (percent)	Case mix adjusted increase (percent)	Average 2-year increase (percent)
1989.....	2.52	4.20	
1990.....	2.08	3.31	3.76

¹ These figures represent the capital cost per case, with adjustments for the anticipated effects of cost report audits and reopenings, based on data in the December 1991 update of the HCRIS file. Differences between these figures and the figures in other charts is due to revised data in successive HCRIS updates. For example, the figure for average cost per case used in setting the PPS-capital rate for FY 1989, \$527.22, was the 1989 average cost per case, with adjustments for audits and reopenings, based on data from the June 1991 HCRIS update. The figure of \$518.90 for FY 1989 in this chart was derived from data in the December 1991 HCRIS update, the latest update available before the publication of the NPRM.

As we noted when we published the June 4, 1992 proposed rule, some cost reports were not included in the HCRIS data we used to compute the proposed update (57 FR 23692). We believed at the time that the missing data was probably from cost reporting periods ending June 30, which include a relative high proportion of hospitals with higher capital costs.

In determining the budget neutrality target for FY 1993 in the proposed rule, we estimated that the final FY 1990 rate of increase in the average cost per case would be 9.6 percent rather than the 5.46 percent increase indicated by the available data on actual costs. Since the

regulation provides that the capital update factor be computed as the 2-year average of actual increases in capital-related costs per case, we believed it was more appropriate to use the 5.46 percent supported by actual cost data rather than an estimated increase for FY 1990. (We did, however, use the estimated increase for budget neutrality purposes). As several commenters acknowledged, we made it clear in the proposed rule that we would recompute the average increase using the latest data, and that the results would not necessarily be the same. The latest FY 1990 cost per case rate of increase (8.45 percent) is, in fact, closer to our estimate for budget neutrality purposes than to the calculated rate of actual increase in the proposed rule. It is also similar to the projected FY 1990 rate of increase in the August 31, 1991 final rule.

We emphasize that even though we use cost report data as the basis for our estimates of FY 1993 capital costs, the budget neutrality target is determined by the estimate of FY 1993 capital costs, not by the 2-year average update factor applied to the FY 1992 Federal rate.

Furthermore, as the data on the HCRIS file continue to be updated for the effects of cost report audits, reopenings, and other factors, the FY 1989 increase in average capital cost per case has also risen to 8.55 percent. In

this case, the rise in the rate of increase from FY 1988 to FY 1989 was primarily due to a relatively greater decline in the FY 1988 average capital cost per discharge compared to the FY 1989 decline reported in the HCRIS data.

We computed the final update factor of 6.07 percent from the data for all short-term acute care hospitals, including hospitals under alternative payment waivers. We used the group of all short-term acute care hospitals because these hospitals are all similar and the waivers could be terminated at some future date. Furthermore, we use all short-term acute care hospitals for related program purposes, such as determining DRG relative weights. (Since waived hospitals will not be paid prospectively in FY 1993, we excluded them from the budget neutrality determination. We discuss this issue in section III.A.4 below.) Contrary to the assertions of some commenters, including hospitals excluded from the prospective payment system in the determination of the 2-year average rate of increase would have slightly increased the update factor by 0.13 percent.

The final update factor of 6.07 percent is actually 0.10 of a percentage point higher than the 5.97 percent projected for FY 1993 in the August 30, 1993 final rule, and 2.31 percentage points higher

than the FY 1993 update of 3.76 percent proposed in the June 4, 1992 proposed rule. Because the issues relating to the

revised capital update factor in this final rule are so complex, we have developed the following more detailed chart to

show how the final FY 1993 update factor was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number hospitals 1st HCR	Number hospitals 2nd HCR	Unadj. capital cost per case	Increase in cost per case (Unadj.)	Audit adjusted capital cost per case ¹ (percent)	Increase in adjusted cost per case (percent)	Average two increase in adjusted cost per case (percent)	Observed CMI (percent)	Adj. to CMI (percent)	Adjusted CMI (percent)	Adjusted increase (percent)	Update (Average two year increase of CMI adjusted rate of increase) (percent)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1988.....	4,329	5,600	\$467.50		\$468.04							
1989.....	4,298	5,486	517.31	10.65	508.06	8.55		2.52		2.52	5.88	
1990.....	4,259	5,406	582.20	12.54	551.07	8.47	8.51	0.86	1.22	2.09	6.25	6.07

¹ Columns 1 and 2 represent the numbers of hospital cost reports used in developing the capital cost per case figure in column 3. Since hospital cost reporting periods do not all coincide with the Federal fiscal year, data for a given Federal fiscal year must be derived from more than one hospital cost report, allocated proportionately to the Federal fiscal year. For example, for a hospital with a cost reporting period beginning January 1, one quarter of its cost report for the period ending December 31, 1987 would be allocated to Federal fiscal year 1988, and three quarters of its cost report for the period ending December 31, 1988 would be allocated to Federal fiscal year 1987. Column 1 represents the number of cost reports used that ended in the Federal fiscal year in question. Column 2 represents the number of cost reports used that began in the Federal fiscal year in question. Column 2 is greater than Column 1 because Column 2 includes cost reports for hospitals whose cost reporting period coincides with the Federal year along with cost reports for those hospitals whose cost reporting periods do not coincide with the Federal fiscal year. Column 1 includes only cost reports for hospitals whose cost reporting periods do not coincide with the Federal fiscal year.

² Figures in column 5 represent the capital cost per case, adjusted for the anticipated effects of cost report audits and reopenings, from the June 1992 update of HCRIS. This column is equivalent to the column labelled Capital Cost per Case in the previous chart showing the computation of the update factor in the June 4, 1992 proposed rule. Differences between the capital cost per case figures used in this chart and in previous charts are due to use of more recent HCRIS data. The following factors were used in adjusting the capital cost per case figures from column 3 for the effects of audits and reopenings:

Audit Adjustment Applied to As-Submitted Cost Reports

Cost reporting periods beginning in:

FY 1987—0.9276

FY 1988—0.9238

FY 1989—0.9212

FY 1990—0.9430

Audit Adjustment Applied to Settled Cost Reports

All years—1.0034

The cost per case figures that result after the application of these audit adjustments to submitted and settled costs reports, respectively, are entered in Column

5.

We note that the effect of the update on the Federal rate is limited by the requirement of budget neutrality until FY 1996. Although the update is 2.31 percentage points higher than in the proposed rule, the final FY 1993 Federal rate has only increased 0.22 percent from the proposed FY 1993 rate. It is only 0.41 percent higher than last year's Federal rate, and 2.99 percent lower than the FY 1993 projection in the August 30, 1992 final rule. This is due primarily to the change in the budget neutrality adjustment factor required to assure that payments in FY 1993 will equal 90 percent of what we estimate would have been paid for capital-related costs on a reasonable cost basis. We discuss the change in this factor, and the reasons for that change, in III.A.3 below.

Comment: Some commenters requested clarification of the discrepancy between our estimates of the FY 1989 and FY 1990 increases in the average capital cost per case in the August 1991 projection and the June 1992 final rule.

Response: The following table summarizes the figures we have used at various times for the FY 1989 and FY 1990 rates of increase in capital cost per case.

RATES OF INCREASE IN CAPITAL COST PER CASE

	FY 1989 (per-cent)	FY 1990 (per-cent)
FY 1992 Final Rule.....	¹ 7.82	² 8.37
FY 1993 Proposed Rule.....	¹ 6.83	¹ 5.46
FY 1993 Final Rule.....	¹ 8.55	¹ 8.47

¹ Cost report calculations with audit adjustments.

² Estimate.

As the chart shows, all the figures for the FY 1989 increases were calculated from cost report data with adjustments for the anticipated effects of audits. The FY 1990 figure in the August 30, 1991 final rule was an estimate; the other figures for FY 1990 were calculated from cost report data. The variation in the figures calculated from cost report data is due entirely to changes in that data from one HCRIS update to another. The effects of audits have varied from our adjustments for their projected effects. We base our audit adjustment on the reported effects of previous audits. If the effect of audits on cost reports that are audited later differs from the effect of cost reports audited earlier, then the audit-adjusted capital cost per case will

also vary from one HCRIS update to the next.

Comment: One commenter requested an explanation of the 1.22 percent adjustment to case mix increase for FY 1990 used in the computation of the capital update in the June 4, 1992 proposed rule. The commenter noted that the update would have been 4.38 percent without this adjustment.

Response: As we explained in the final rule for FY 1990 (54 FR 36471), 1.22 percent of the total increase in case mix from FY 1987 to FY 1988 resulted from FY 1988 GROUPE changes and recalibration. In other words, 1.22 percent of the increase of case mix from FY 1987 to FY 1988 did not represent an increase in resource requirements that should be recognized in increased payments in subsequent years. To assure that this distortion was not continued into subsequent years, we reduced the FY 1990 weights to remove prospectively the 1.22 percent increase in the average case weight attributable to GROUPE changes and recalibration in FY 1988. In computing the capital update factor, we adjust the rate of increase in capital cost per case for each year used in determining the update for observed case mix increase in that year.

Since 1.22 percent was removed from the FY 1990 weights to adjust for the effects of administrative changes on the DRG weights in 1988, that reduction must be reincorporated into the FY 1990 case mix increase. Case-mix increases for this purpose must be determined with consistent measures of case mix in two comparison years. The 1.22 percent adjustment corrects this inconsistency in determining the appropriate FY 1990 rate of increase. Otherwise, the adjustment would not be based on total observed case-mix increase for FY 1990.

Comment: Two commenters recommended that an add-on adjustment be employed in setting the update factor to account for appropriate changes in new technology prior to the adoption of an analytical update framework in FY 1996.

Response: The present update factor is based on a two-year lagged average of actual costs. Since actual costs include spending for new technology, the cost of new technology is already accounted for in the update factor. A separate adjustment for new technology is therefore not appropriate (and would be double counting) as long as the update is determined by a lagged average of actual costs. The cost of appropriate new technology is one of the factors that we believe should be included in the analytical update framework that will be used beginning in FY 1996. As we discuss in appendix D, we are studying methodologies for incorporating appropriate changes of cost due to new technology along with other factors into the update framework for FY 1996 and beyond.

Comment: One commenter alleged that HCFA was violating its commitment to provide fair and just capital updates by playing budget games with the capital update factor.

Response: The computation of the proposed update factor for FY 1993 was not driven by budget considerations. We employed the methodology established in the August 30, 1991 final rule implementing the capital prospective payment system and the best data available to us at the time to compute the proposed FY 1993 rate. As explained above, the change in the final update factor for FY 1993 is due to more complete and accurate data than were available at the time when we computed the proposed update. As also explained above, the major constraint on the increase in the Federal rate in FY 1993 is the budget neutrality requirement. This requirement was established by statute and we have no discretion in applying it. The update factor is determined independently of the budget neutrality adjustment.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 20 percent for cost reporting periods beginning in FY 1993 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that 5.1 percent of estimated inpatient operating payments are paid as outlier payments. The inpatient capital-related outlier reduction factor is then set according to the estimated inpatient capital-related outlier payments that would be made if hospitals were all paid according to 100 percent of the Federal rate. It is appropriate, for purposes of calculating the outlier thresholds and the outlier reduction factor, to model all hospitals as if paid 100 percent of the Federal rate. This is because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

For FY 1992, we estimated that outlier payments would equal 5.03 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9497 to the Federal rate. In the June 4, 1992 proposed rule, we proposed an outlier reduction factor of 0.9490. Based on the thresholds as set forth in section VI of the preamble to this final rule, we estimate that outlier payments will equal 5.04 percent of inpatient capital-related payments based on the Federal rate in FY 1993. We are therefore applying an outlier adjustment factor of 0.9496 to the Federal rate.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore the net change in the outlier adjustment to the Federal rate for FY 1993 is 0.9496/.9497 or 0.9999. Thus, the higher outlier payment percentage in FY 1993 will reduce the FY 1993 Federal rate by an additional .01 percent ($1 - 0.9999$)

compared with the FY 1992 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Weight and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments for the fiscal year based on any changes resulting from the annual reclassification and recalibration of the DRG weights and in the geographic adjustment factor equal estimated aggregate payments that would have been made on the basis of the Federal rate without such changes.

We proposed to adjust the Federal rate to maintain budget neutrality for changes in DRG weight and the geographic adjustment factor by a factor of 0.9906. In this final rule, we are applying a factor of 0.9980 to meet this requirement.

Comment: One commenter observed that the application of the "new" factor to preserve budget neutrality for changes resulting from any annual recalibration and reclassification of the DRG weights and in the geographic adjustment factor accounted for almost 1 percentage point of the 3.21 percent difference between the projection of the FY 1993 Federal rate in the August 30, 1991 final rule and the proposed FY 1993 Federal rate.

Response: This adjustment factor is not new in the sense that provision was made for the adjustment in the August 30, 1991 final rule implementing the capital prospective payment system. Consistent with the prospective payment system for operating costs, we believe that changes in the DRG weights and geographic adjustment factor (including those resulting from geographic reclassifications) should be budget neutral. The adjustment is applied for the first time this year since it was designed to adjust for all changes in DRG weights and in the geographic adjustment factor after the initial year of the capital prospective payment system.

We use the actuarial model described in Appendix B to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the geographic adjustment factor. We also use the model to estimate aggregate payments that would have been made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the geographic adjustment factor. For FY 1993, we

estimated in the proposed rule that a budget neutrality factor of 0.9906 was necessary for this purpose. For the final rule, we have determined that a factor of 0.9980 is necessary. Appendix B contains a more detailed description of the methodology used to determine this factor. We note that this factor accounts only for changes due to DRG classification changes and recalibration and in the geographic adjustment factor. It does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors. It incorporates the effects of the geographic adjustment factor of FY 1993 geographic reclassification decisions made by the MGCRB compared to FY 1992 decisions.

4. Budget Neutrality Factor To Assure Aggregate Payments Equal 90 Percent of Reasonable Cost Payments

As amended by section 4001(b) of Public Law 101-508, section 1886(g)(1)(A) of the Act requires that aggregate payments made each year from FY 1992 through FY 1995 for hospital inpatient services be reduced in a manner that results in savings equivalent to 10 percent of what HCFA estimates would have been payable on a reasonable cost basis for inpatient capital-related costs in that year. The Conference Committee report accompanying Pub. L. 101-508 indicated that, prior to the fiscal year, the Secretary may estimate the budget neutrality adjustment based on the best available information (H.R. Conf. Rep. No. 964, 101st Cong., 2nd Sess. 691 (1990)). In keeping with the legislation, no retroactive adjustment is made if aggregate payments are greater than or less than 90 percent of actual Medicare inpatient capital-related costs for that year.

Section 412.352 of the regulations provides that HCFA determines an adjustment to the hospital-specific rate and the Federal rate proportionately, so that the estimated payments for capital in each year from FY 1992 through FY

1995 will equal 90 percent of what would have been payable that year on a reasonable cost basis. The effect of this provision is that the savings required under section 1886(g)(1)(A) of the Act are realized entirely through a reduction in payment for capital costs in FY 1992 through FY 1995.

We proposed a budget neutrality adjustment factor of 0.9564. In this final rule, we are establishing a budget neutrality factor of 0.9162. One reason for the change in the budget neutrality factor since the June 4, 1992 proposed rule is a decline in the projected FY 1993 capital cost per case budget neutrality target. We develop this target from available data on the average Medicare capital cost per case of all short-term acute care hospitals subject to the capital prospective payment system (excluding waiver hospitals), which we update to FY 1993 on the basis of estimated rates of increase in Medicare capital costs per case. The FY 1993 capital cost per case budget neutrality target declined 3.12 percent from the June 4, 1992 proposed rule to this final rule. Two significant factors account for this decline. One factor is the decline in the Medicare capital cost per case reported in the HCRIS updates. We believe that this decline is due to actual audit reductions higher than we originally projected. The second factor is a decline in our latest estimates of the projected increases in Medicare capital costs per case.

For the June 4, 1992 proposed rule, we had data from the December 1991 HCRIS update on the average Medicare capital cost per case for all hospitals in FY 1989. We adjusted this figure for the effects of audits and developed a projected average Medicare capital cost per case for FY 1993 on the basis of estimated rates of increase in Medicare inpatient capital cost per case. We then used the projected FY 1993 average Medicare capital cost per case as the budget neutrality target for FY 1993, and computed the budget neutrality adjustment accordingly.

For this final rule, we have actual data for FY 1990 from the June 1992 HCRIS update. Therefore, we are able to use FY 1990 capital costs per case rather than FY 1989 costs per case as the basis for projecting a FY 1993 average capital cost per case budget neutrality target. In computing the final FY 1993 budget neutrality target, we adjusted the FY 1990 capital cost per case for the effect of audits as we had done in the June 4, 1992 proposed rule for the FY 1989 amount. We eliminated the data from excluded and waiver hospitals, so that the average capital cost per case is based only on short-term acute care hospitals subject to the capital prospective payment system. Eliminating the waiver hospitals from the budget neutrality determination has the effect of raising the capital cost per case by 0.7 percent (from \$551.07 per case to \$554.94 per case) compared to using all short-term acute care hospitals including those in waiver states. We also adjusted the FY 1990 average Medicare capital costs for expansion of the preadmission DRG window and for the effects of transfers on the total discharge count used to determine the Medicare cost per case. We made both these adjustments in calculating the FY 1989 Medicare inpatient cost per case in the August 30, 1991 final rule (56 FR 43368). We included these adjustments in the budget neutrality target computation for consistency. Finally, we applied revised estimates of the rate of increase in capital costs per case between FY 1990 and FY 1993 to arrive at a projected FY 1993 average Medicare capital cost per case.

In the June 4, 1992 proposed rule, we estimated there would be a 29.1 percent increase in Medicare inpatient capital costs per case, between FY 1990 and FY 1993. In this final rule, we estimate the increase over that period will be 26.9 percent. The following chart shows how the rate of increase estimates for FY 1991 through FY 1992 were calculated in the June 4, 1992 proposed rule and for this final rule:

COMPARISON OF FACTORS FOR MEDICARE INPATIENT CAPITAL COST PER CASE INCREASES: NPRM AND FINAL RULE

[In Percentages]

FY	(1) Total inpatient capital			(2) Medicare share			(1) x (2) = (3) Medicare inpatient capital			(4) Medicare enrollment			(5) Admissions incidence			(4) x (5) = (6) Medicare admissions			(3)/(6) = (7) Estimated increase in Medicare inpatient capital cost per case		
	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change
91.....	5.99	5.81	-0.17	2.94	2.34	-0.58	9.11	8.28	-0.76	2.19	2.19	-0.00	-0.72	-0.71	0.01	1.46	1.47	0.01	7.54	6.71	-0.77
92.....	8.00	8.00	0.00	3.00	3.00	0.00	11.24	11.24	0.00	1.99	2.22	0.23	-0.03	0.25	0.28	1.96	2.47	0.50	9.10	8.56	-0.50
93.....	9.00	9.00	0.00	3.30	3.30	0.00	12.60	12.60	0.00	1.73	2.11	0.37	0.56	0.82	0.06	2.30	2.75	0.44	10.07	9.58	-0.45

The chart shows the causes of the decline in the rate of increase projections. For FY 1991, the decline in the projected rate of increase is due to the 0.17 percent decline in the projected rate of increase of total Medicare capital and the 0.58 percent decline in the projected rate of increase of Medicare dayshare. Together these factors produced a 0.76 percent decline in the projected rate of increase of Medicare inpatient capital. Combined with a 0.01 percent rise in the projected rate of increase of Medicare admissions, this produced a 0.77 percent decline in the projected rate of increase of Medicare capital cost per case. For FY 1992 and FY 1993, the decline is due to higher projected rates of increase in Medicare admissions (0.50 percent and 0.44 percent respectively). These changes are due in turn to higher projected rates of increase for Medicare enrollment (0.23 percent for FY 1992 and 0.37 percent for FY 1993) and higher projected rates of increase for admissions incidence (0.28 percent for FY 1992 and 0.06 percent for FY 1993).

The revised figures employed in this final rule come from our regular mid-session budget review. The revised figures for FY 1991 derive from actual data which differed from our projections. For FY 1992, we now have preliminary data that shows admissions are increasing. We expect these increases to continue into FY 1993. Accordingly, we have raised our estimates of the rate of increase in admissions for the rest of FY 1992 and for FY 1993. The higher rates of increase in enrollment are based on SSA data that have become available since the June 4, 1992 proposed rule and show an increase in the disability population.

The following chart shows the effect of the reduced rates of increase by comparing the projections from FY 1990 to FY 1993 in the proposed rule and in the final rule:

EFFECT OF REVISED RATE OF INCREASE
ESTIMATES ON CALCULATION OF FY
1993 BUDGET NEUTRALITY TARGET

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
FY 1990:			
Proposed.....	\$568.66 ¹		
Final.....	560.49 ²	N/A	-1.44
FY 1991:			
Proposed.....	611.54		
7.54%.....			
Final 6.71%.....	598.10	-0.77	-2.20

EFFECT OF REVISED RATE OF INCREASE
ESTIMATES ON CALCULATION OF FY
1993 BUDGET NEUTRALITY TARGET—
Continued

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
FY 1992:			
Proposed.....	667.19		
9.10%.....			
Final 8.56%.....	649.30	-0.49	-2.68
FY 1993:			
Proposed.....	734.38		
10.07%.....			
Final 9.58%.....	711.50	-0.45	-3.12
Cumulative.....		-1.70	

¹ FY 1990 estimate, based on December 1991 HCRIS data (audit-adjusted) for FY 1989 and estimated rate of increase of 9.59 percent.

² FY 1990 cost per case based on June 1992 HCRIS data, audit-adjusted, excluding waiver hospitals and PPS-excluded hospitals, and adjusted for preadmission DRG window and transfers.

The chart shows that the cumulative effect on the revised rates of increase is to lower the FY 1993 budget neutrality target by 1.70 percent. Together with the 1.44 percent decline due to updated HCRIS data, this accounts for the 3.12 percent reduction in the FY 1993 capital cost per case budget neutrality target.

In addition to the lower FY 1993 capital cost-per-case budget neutrality target, the other factor that contributes to the revised budget neutrality adjustment factor in this final rule is higher update factor for the Federal and hospital-specific rates. Even without a decrease in the budget neutrality target, the higher update factor would have produced high payments based on those rates that would have required a reduction in the budget neutrality adjustment factor.

One implication of the revised capital cost per case budget neutrality targets is that, based on current data, the budget neutrality adjustment for FY 1992 was not sufficient to meet the 90 percent target. As a consequence, the Federal rate for FY 1992 was higher than it should have been on the basis of the revised capital cost per case estimates. While we do not retroactively adjust budget neutrality factors for previous years to account for revisions in our estimates, we do employ the information obtained through our monitoring efforts to refine the budget neutrality adjustment for subsequent years. Thus, in this final rule, we use the most recently available data to establish the budget neutrality adjustment for FY 1993. For FY 1993, we proposed to apply a budget neutrality factor of 0.9564 to realize the required expenditure level. The budget neutrality factors are not

built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. In this final rule, the budget neutrality adjustment factor is 0.9162. This represents a net -4.58 percent adjustment (.9162/.9602 = .9542) to the FY 1992 Federal rate, and a net adjustment of -4.20 percent (.9162/.9564 = .9580) in the FY 1993 Federal rate proposed in the June 4, 1992 proposed rule.

5. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments for exceptions under § 412.348 determined as a proportion of total payments under the hospital-specific rate and Federal rate. The model developed for determining the budget neutrality adjustment factor is also used to estimate payments under the exceptions payment process and to determine the exceptions payment adjustment factor.

For FY 1992, we estimated that exceptions payments would equal 1.87 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of .9813 (1-0.0187) in determining the Federal rate. For FY 1993, we estimated in the June 4, 1992 proposed rule that exceptions payments would equal 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed to apply an exceptions reduction factor of 0.9610 to determine the FY 1993 Federal rate. For this final rule, we are estimating that exceptions payments for FY 1993 will equal 2.44 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are therefore applying an exceptions payment reduction factor of 0.9756 to the Federal rate for FY 1993.

We expect exceptions payments to increase during the transition period as payments are increasingly based on the Federal rate. This accounts for the higher level of exceptions payments for FY 1993 compared to FY 1992. The lower level of exceptions payments in this final rule compared to the proposed rule is due to the lower projected FY 1993 capital costs per case, which has the effect of reducing the number of hospitals that qualify for an exception and the amount of the exception for those that do qualify.

The exceptions reduction factors are not built permanently into the rates; that

is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net adjustment to the FY 1993 Federal rate is -0.58 percent (.9756/.9813, or 0.9942) in comparison to the FY 1992 Federal rate, and +1.52 percent (.9756/.9610 or 1.0152) in comparison to the proposed Federal rate.

6. Standard Federal Rate for FY 1993

For FY 1992, the Federal rate was \$415.59. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1993 Federal rate would be \$416.36. In this final rule, we are establishing an FY 1993 Federal rate of \$417.29. The final Federal rate for FY 1993 was calculated as follows:

- The FY update factor is 1.0607.
- The FY 1993 outlier adjustment factor is 0.9496.
- The FY 1993 budget neutrality factor applied to the standard Federal rate for changes in the DRG relative weights and in the geographic adjustment factor is 0.9980.

• The FY 1993 budget neutrality adjustment factor that is applied to the standard Federal payment rate and the hospital-specific rate to assure that aggregate payments equal 90 percent of payments that would have been made on a reasonable cost basis is 0.9162.

- The FY 1993 exceptions payment adjustment factor is 0.9756.

Since the Federal rate had already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we proposed to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factors for changes in the DRG relative weights and the geographic adjustment factor.

Comment: We received 15 comments on the proposed FY 1993 capital Federal rate. All the commenters noted that the proposed FY 1993 rate represented only a small increase over the FY 1992 rate. Seven commenters noted that the

proposed FY 93 Federal rate was 3.21 percent lower than the rate of \$430.17 projected in the August 30, 1991 final rule (56 FR 43522). One commenter also noted that while reasonably accurate projections of the budget neutrality adjustment and the exceptions reduction factor were included in the August 30, 1991 final rule projection, the projection did not include an estimate of the effects of the budget neutrality adjustment for case-mix change and change in the geographic adjustment factor. The commenter noted that this accounted for 1 percentage point of the difference between the August 1991 projection and the proposed FY 1993 Federal rate.

Seven commenters expressed concern that the proposed increase in the Federal capital rate would not be adequate to meet hospitals' Medicare capital-related costs. Three commenters noted that the small increase in the proposed Federal capital rate had already made it more difficult or more costly for hospitals to borrow. One commenter noted that the investment community places great (perhaps symbolic) importance on the amount of the Federal rate over total per case capital payments in judging whether hospitals are likely to have adequate funds under the capital prospective payment system to meet debt service.

Response: We explain in detail below the reasons why the FY 1993 Federal rate is lower than the rate projected in the August 30, 1991 final rule. We believe it is important to keep in mind, however, that while the Federal rate has increased by only 0.4 percent, largely because of budget neutrality constraints, we estimate total capital payments will increase by 6.2 percent.

We are sensitive to the concerns of hospitals that there be predictability in the levels of their capital payments. We make our projections based on the best data available at the time, and we share them so that others will have the most current information on what we estimate capital payments will be over the next few years. At the same time, we have a statutory obligation to assure that payments equal 90 percent of what

would have been available on a reasonable cost basis and to revise our estimates for rate-setting purposes as better data become available. When we published the projections for fiscal years 1993 through 1996 in the August 30, 1991 final rule, we cautioned that they were only estimates, and that they were subject to revisions resulting from continued methodological refinements, more recent data, and payment policy changes. Some difference between the projection and the proposed FY 1993 Federal rate were therefore only to be expected.

The chart below compares the final FY 1993 Federal rate with the August 1991 projection. As the chart shows, the final update factor of 6.07 percent is slightly higher (0.09 percent) than the August 1991 projection. While the final FY 1993 GAF/DRG budget neutrality factor and the final outlier reduction factor have the effect of slightly decreasing the Federal rate (0.20 percent and 0.01 percent, respectively) in comparison to the projection, the final exceptions reduction factor has the effect of increasing the Federal rate by 1.57 percent compared to the projection. Our August 30, 1991 projection did not include the DRG/GAF budget neutrality factor because we had no basis for predicting the additional FY 1993 geographic reclassifications. While we estimate exceptions payments will be higher in FY 1993 than they were in FY 1992, they will be lower than we projected in August, 1991. This is probably due to the lower FY 1993 capital cost-per-case budget neutrality target for FY 1993, as we explained in section III.A.5. above. Finally, the major cause for the decrease in the final FY 1993 Federal rate compared to the August 1991 projection is the budget neutrality adjustment factor. We have explained the effects of the lower FY 1993 budget neutrality target and the higher FY 1993 update factor on the determination of the final budget neutrality adjustment factor for FY 1993 in section III.A.4. above.

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FINAL FY 1993 RATE

	Cost per discharge Projection	Percent change from FY 93	Cumulative percent change
FY 89 cost per discharge.....	\$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters.....	464.42		
Update factor:			
Projection: 1.0597.....	492.15		
Final FY 93: 1.0607.....	492.61	0.09	0.09
GAF/DRG budget neutrality factor:			
Projection: 1.0000.....	492.15		
Final FY 93: 0.9980.....	491.83	-0.20	-0.11

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FINAL FY 1993 RATE—Continued

	Cost per discharge	Percent change from FY 93	Cumulative percent change
	Projection		
Outlier reduction factor:			
Projection: 0.9497	467.39		
Final FY 93: 0.9496	466.85	-0.01	-0.12
Exceptions reduction factor:			
Projection: 0.9605	448.93		
Final FY 93: 0.9756	455.46	1.57	1.45
Budget neutrality reduction factor:			
Projection: 0.9582	430.17		
Final FY 93: 0.9162	417.29	-4.38	-2.99
Net change:			
Projected FY 93 rate:	430.17		
Final FY 93 rate:	417.29	-2.99	

We provide below a comparison of the final rate calculation that accounts for changes in the Federal rate from FY 1992. At each step, dollar amounts are shown to illustrate the cumulative effect on the Federal rate of each adjustment factor, and the difference in the effect of each adjustment factor between the final FY 1992 rate and the final rate for FY 1993. The cumulative percent change

column shows the difference, to that point in the table, between the FY 1992 rate and the final FY 1993 rate.

The 1993 update increases the Federal rate 6.07 percent compared to the rate in FY 1992 while the DRG/GAF budget neutrality factor decreases the Federal rate by 0.20 percent. The exceptions reduction factor decreases the proposed Federal rate by 0.58 percent compared to

the exceptions reduction for FY 1992. The budget neutrality adjustment factor reduces the FY 1993 rate by 4.58 percent compared to the budget neutrality reduction in FY 1992. The combined effect of all the changes is to increase the FY 1993 Federal rate by 0.41 percent over the FY 1992 Federal rate.

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 1992 FINAL RULE TO FY 1993 FINAL RULE

	Cost per discharge	Percent change from FY 92 rate from FY 92 (percent)	Cumulative percent change
FY 89 cost per discharge	\$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters	464.42		
Update factor:			
FY 92	464.42		
FY 93: 1.0607	492.61	6.07	6.07
GAF/DRG budget neutrality factor:			
FY 92: 1.0000	464.42		
FY 93: 0.9980	491.63	-0.20	5.86
Outlier reduction factor:			
FY 92: 0.9497	441.06		
FY 93: 0.9496	466.85	-0.01	5.85
Exceptions reduction factor:			
FY 92: 0.9813	432.81		
FY 93: 0.9756	455.46	-0.58	5.23
Budget neutrality reduction factor:			
FY 92: 0.9602	415.59		
FY 93: 0.9162	417.29	-4.58	.41
Net change:			
FY 92 rate	415.59		
FY 93 rate	417.29	.41	

Below we are providing a chart that demonstrates how our final FY 1993 Federal rate differs from the proposed FY 1993 Federal rate. The final update factor has the effect of raising the Federal rate by 2.23 percent. The revised DRG/GAF budget neutrality adjustment

and outlier reduction factor have the effect of increasing the Federal rate marginally, and the revised exceptions reduction factor has the effect of increasing the Federal rate by 1.52 percent. However, the revised budget neutrality adjustment factor has the

effect of decreasing the Federal rate by 4.20 percent, thus producing an increase of only 0.22 percent in the FY 1993 Federal rate between the June 4, 1992 proposed rule and this final rule.

COMPARISON OF FY 1993 PROPOSED FEDERAL RATE TO FY 1993 FINAL FEDERAL RATE

	Cost per discharge proposed	Percent change from FY 93 proposed (percent)	Cumulative change from FY 93 (percent)
FY 89 cost per discharge.....	\$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters.....	464.42		
Update factor:			
Proposed FY 93: 1.0376.....	481.88		
Final FY 93: 1.0607.....	492.61	2.23	2.23
GAF/DRG budget neutrality factor:			
Proposed FY 93: 0.9906.....	477.35		
Final FY 93: 0.9980.....	491.63	.75	2.99
Outlier reduction factor:			
Proposed FY 93: 0.9490.....	453.01		
Final FY 93: 0.9496.....	466.85	.06	3.06
Exceptions reduction factor:			
Proposed FY 93: 0.9610.....	435.34		
Final FY 93: 0.9756.....	455.46	1.52	4.62
Budget neutrality reduction factor:			
Proposed FY 93: 0.9564.....	416.36		
Final FY 93: 0.9162.....	417.29	-4.20	.22
Net change:			
Proposed FY 93 rate.....	416.36		
Final FY 93 rate.....	417.29	.22	

We estimated in the June 4, 1992 proposed rule that capital payments per case would increase 7.7 percent in FY 1993. With the lower budget neutrality target in this final rule, we project that capital payments per case will increase 6.2 percent in FY 1993. It is to be expected that the rate of increase in the Federal rate will generally be lower than the rate of increase in payments. As capital costs per case increase, total capital payments per case will increase proportionately through FY 1995 because of the requirement that aggregate payments for capital-related costs equal 90 percent of what would have been payable on a reasonable cost basis. At the same time, the amount of exceptions payments will increase as the transition progresses. These higher exceptions payments must be offset in the Federal rate determination, which reduces the increase in the Federal rate. For FY 1993, we expect exceptions payments to be more than twice as much as in FY 1992. The increase in capital payments per case is a much more important factor in gauging the adequacy of reimbursement under the capital prospective payment system than changes in the Federal rate alone. We believe that the projected increase in capital payments per case of 6.2 percent should be sufficient to provide adequate payment to hospitals to cover their Medicare related costs. In this regard, we note that the 6.2 percent increase is in relation to FY 1992 payment levels that we now estimate will equal 92.85 percent of what would have been payable on a reasonable cost basis (instead of 90 percent as required by statute). If FY 1992 payments had not

been excessive, the FY 1993 increase would be 9.6 percent.

7. Rate for Puerto Rico Hospitals

For FY 1992, the rate for Puerto Rico hospitals was \$319.68. With the changes we proposed making to the factors used to determine the rate, the FY 1993 standard rate for Puerto Rico would have been \$320.27. With the changes we are adopting in this final rule, the standard rate for Puerto Rico is \$320.99.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate each year be determined by adjusting the FY 1992 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1993, we proposed that the hospital-specific rate be updated by a factor of 1.0376. In this final rule, we are updating the hospital-specific rate by a factor of 1.0607.

2. Exceptions Payment Adjustment Factor

For FY 1992 through FY 2001, the updated hospital-specific rate is reduced by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1993, we estimated in the proposed rule that

exceptions payments would be 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore proposed that the updated hospital-specific rate be reduced by a factor of 0.9610. In this final rule, we are applying an exceptions reduction factor of 0.9756 to the hospital-specific rate. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate compared to FY 1992 would therefore be -.58 percent (.9756/.9813 or .9942).

3. Budget Neutrality Adjustment Factor

For FY 1992 through FY 1995, the updated hospital specific rate is adjusted by a budget neutrality adjustment factor determined under § 412.352 of the regulations so that estimated aggregate payments under the capital prospective payment system will equal 90 percent of what would have been payable on a reasonable cost basis. (The budget neutrality adjustment for changes in the DRG relative weights and in the geographic adjustment factor is not applied to the hospital-specific rate.) For FY 1993, we proposed a budget neutrality factor of 0.9564. In the final rule, we are applying a budget neutrality factor of 0.9162 to the hospital-specific rate. The budget neutrality factor is not built permanently into the rates; that is, the factor is not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate in comparison to

FY 1992 would therefore be -4.58 percent (.9162/.9602 or .9542).

4. Net Change to Hospital-Specific Rate

We are providing a chart below to show the net change to the hospital-specific rate. The chart shows the factors for FY 1992 and FY 1993 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1992 to FY 1993 is 1.0062, which represents an increase of 0.62 percent to the hospital-specific rate. The FY 1993 hospital-specific rate for each hospital is determined by multiplying the FY 1992 hospital-specific rate by the cumulative net adjustment of 1.0062.

FINAL FY 1993 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update Factor:			
FY 92:			
FY 93:	1.0607	1.0607	6.07
Exceptions payment adjustment factor:			
FY 92:	0.9813		
FY 93:	0.9755	0.9942	-0.58
Budget neutrality adjustment factor:			
FY 92:	0.9602		
FY 93:	0.9162	0.9542	-4.58
Cumulative adjustments:			
FY 92:	0.9422		
FY 93:	0.9481	1.0062	0.62

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1993

Comment: One commenter expressed concern over HCFA's use of the hospital wage index to adjust the Federal rate for local cost variations (the geographic adjustment factor). The commenter maintained that the use of the area wage index for payment to hospitals for purchases of new equipment is inappropriate since the cost of equipment from national manufacturers is unrelated to a hospital's geographic location. The commenter thus recommended the development of a more accurate index.

Response: The formula for the geographic adjustment factor already accounts for the concern expressed in the comment. The adjustment factor equals the hospital wage index value applicable to a hospital raised to the .6848 power and is applied to 100 percent of the Federal rate. When the

wage index is raised to the .6848 power, it has the effect, on average, of adjusting .6848 of the Federal rate by the wage index. This means that only the part of the Federal rate which is actually affected by local cost variations, rather than the part which is determined by uniform national costs for equipment, is adjusted by the wage index. The exponential form is used in order to apply one factor to the whole capital payment, rather than forming labor and nonlabor shares. The present formula still provides the most accurate adjustment available to account for local cost variation. As we explained in the preamble to the August 30, 1991 final rule for the capital prospective payment system (56 FR 43374), the use of the hospital wage index was justified by our regression analyses, and the formula was determined in accordance with the results yielded by those analyses. While we still believe that the hospital wage index is the most appropriate basis for the geographic adjustment factor that is currently available, we agree with the commenter that the issue warrants continued study and evaluation.

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two alternative payment methodologies: the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate is determined by adjusting:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's geographic adjustment factor, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, where appropriate).

If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology,

the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor) × (Large Urban Add-on, if applicable) × (for hospitals located in Alaska and Hawaii, COLA adjustment) × (1 + Disproportionate Share Adjustment Factor + Indirect Medical Education Adjustment Factor, if applicable).

The result is termed the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost-reporting period beginning on or after October 1, 1993 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis throughout the transition period.

Payment for each discharge under the fully prospective methodology is the sum of:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 1993 are 20 percent of the adjusted Federal rate and 80 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made

only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that will be 20 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1993. Thus, a fully prospective hospital will receive 20 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1993. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the hospital's outlier payments is included in its payments.

The rules to establish outlier thresholds for FY 1993 are published in section V.A of the preamble to this final rule. For FY 1993, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the larger of 2.0 times the prospective payment rate for the case of \$35,500. A case qualifies as a day outlier for FY 1993 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of three standard deviations of the length of stay or 23 days. For hospitals not subject to capital PPS (such as new hospitals under section 412.300(b) of the regulations), the operating cost outlier threshold is the greater of 2.0 times the operating prospective payment rate or \$32,500. This threshold is derived by apportioning \$35,500 in operating cost using the national average operating and capital cost-to-charge ratios (.6328 and .0594, respectively). This method is the same one used to develop last year's operating only threshold, as described at 56 FR 43227.

During the capital prospective payment system transition period, any hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods occurring in FY 1993 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;

- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent and urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and,

- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first two years of operation and are paid 85 percent of their reasonable costs during that period. As discussed in section VI.A. of the preamble to this final rule, we are clarifying that a new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period will extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.

IV. Target Rate Percentages for Hospitals and Hospital Units Excluded from the Prospective Payment System

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience, trended forward by the

applicable update factors. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

Effective with cost reporting periods beginning on or after October 1, 1991, a hospital that has inpatient operating costs per discharge in excess of its target amount will be paid its target amount plus 50 percent of its costs in excess of the target amount. Total payments may not exceed 110 percent of the target amount. However, a hospital that has inpatient operating costs less than its target amount will be paid its costs plus the lower of—

- Fifty percent of the difference between the inpatient operating cost per discharge and the target amount; or

- Five percent of the target amount.

Each hospital's target amount is adjusted annually, by an applicable target rate percentage. For cost reporting periods beginning on or after October 1, 1992 and ending before October 1, 1993, section 1886(b)(3)(B)(ii) of the Act provides that the applicable percentage increase is the market basket percentage increase. In order to determine a hospital's target amount for its cost reporting period beginning in FY 1993, the hospital's target amount for its reporting period that began in FY 1992 is increased by the market basket percentage increase for FY 1993. The most recent forecasted market basket increase for FY 1993 for hospitals and units excluded from the prospective payment system is 4.2 percent. Therefore, the applicable percentage increase is also 4.2 percent.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1a, 1b, 1c, 3c, 4a, 4b, and 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 1d, 3c, 4a, 4b, 4c, 4d, 4e, 5, 6a, 6b, 6c, 6d, 6e, 6f, 6g, 6h, 7A, 7B, 8a, 8b, and 9 are presented below. The tables presented below are as follows:

- Table 1a—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
- Table 1b—Regional Adjusted Operating Standardized Amounts, Labor/Nonlabor
- Table 1c—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
- Table 1d—Capital Standard Federal Payment Rate
- Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1991

Table 4a—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4b—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4c—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified

Table 4d—Average Hourly Wage for Urban Areas

Table 4e—Average Hourly Wage for Rural Areas

Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, Arithmetic

Mean Length of Stay, and Day Outlier Threshold Used in the Prospective Payment System

Table 6a—New Diagnosis Codes

Table 6b—New Procedure Codes

Table 6c—Invalid Diagnosis Codes

Table 6d—Invalid Procedure Codes

Table 6e—Revised Diagnosis Code Titles

Table 6f—Revised Procedure Code Titles

Table 6g—Additions to the CC Exclusions List

Table 6h—Deletions to the CC Exclusions List

Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay

FY 91 MEDPAR Update 6/92 GROUPE V9.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 6/92 GROUPE V10.0

Table 8a—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted)

Table 8b—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted)

Table 9—1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large Urban		Other Urban		Rural	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2588.38	1066.39	2547.40	1049.51	2621.30	844.54

TABLE 1B—REGIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

	Large urban		Other Urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	2718.22	1113.53	2675.18	1095.89	2906.21	1002.29
2. Middle Atlantic (PA, NJ, NY)	2442.07	1054.94	2403.41	1038.24	2783.27	947.50
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2606.83	873.59	2565.55	958.18	2660.69	821.62
4. East North Central (IL, IN, MI, OH, WI)	2749.57	1151.92	2706.04	1133.68	2694.30	913.15
5. East South Central (AL, KY, MS, TN)	2501.84	681.57	2462.22	867.62	2637.01	766.17
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2607.57	1049.59	2566.29	1032.98	2562.99	818.54
7. West South Central (AR, LA, OK, TX)	2592.57	967.00	2551.51	951.70	2458.00	752.76
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2500.91	1035.78	2481.31	1019.39	2485.70	865.78
9. Pacific (AK, CA, HI, OR, WA)	2432.68	1183.17	2394.18	1164.44	2417.56	975.34

TABLE 1C—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban		Other urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Puerto Rico	2327.98	484.16	2291.12	476.50	1786.74	385.18
National	2581.80	1004.12	2581.80	1004.12	2581.80	1004.12

TABLE 1D.—CAPITAL STANDARD FEDERAL BILLING CODE 4120-03-M
PAYMENT RATE

	Rate
National	417.29
Puerto Rico	320.99

BILLING CODE 4120-03-C

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2807	010065	01.2058	010130	01.1135	030011	01.3734
010004	00.9097	010068	00.9287	010131	01.2425	030012	01.2299
010005	01.1227	010068	01.2062	010134	00.8432	030013	01.2443
010008	01.3393	010069	01.1563	010136	00.9547	030014	01.4031
010007	01.1009	010072	01.1131	010137	01.2988	030016	01.2762
010008	01.0077	010073	00.8980	010138	00.9357	030017	01.3832
010009	01.0273	010078	01.1942	010139	01.5216	030018	01.5880
010010	01.1156	010079	01.1448	010143	01.1285	030019	01.2814
010011	01.3574	010080	00.9558	010144	01.3769	030022	01.4006
010012	01.1928	010081	01.8053	010145	01.2076	030023	01.2054
010015	01.0730	010083	01.0932	010146	01.0485	030024	01.6310
010016	01.0765	010084	01.2908	010148	00.9447	030025	01.0782
010018	00.9150	010085	01.2717	010149	01.3690	030027	01.0651
010019	01.1785	010086	00.9694	010150	01.0028	030030	01.8629
010020	01.0007	010087	01.5097	010152	01.2536	030033	01.3734
010021	01.2115	010089	01.1003	010153	00.8914	030034	01.0286
010022	00.9401	010090	01.4705	010155	01.1307	030035	01.2489
010023	01.2778	010091	01.0189	010898	00.6959	030036	01.2334
010024	01.2337	010092	01.3663	010899	00.5933	030037	01.8935
010025	01.2158	010094	01.1783	020001	01.4834	030038	01.4606
010027	00.8711	010095	01.0181	020002	01.1941	030040	00.9724
010029	01.4931	010096	00.9046	020004	01.0873	030041	00.9511
010031	01.2797	010097	01.0095	020005	00.8988	030043	01.1931
010032	00.9070	010098	01.0219	020006	01.0388	030044	01.1142
010033	01.9500	010099	01.0825	020007	00.8894	030047	00.9812
010034	01.0531	010100	01.1681	020008	01.0337	030049	00.9341
010035	01.1657	010101	01.0596	020009	00.8031	030049	00.9341
010036	01.1478	010102	00.9137	020010	00.9224	030051	01.0494
010038	01.2293	010103	01.5253	020011	00.9338	030054	00.9025
010039	01.5918	010104	01.5707	020012	01.1684	030055	01.1924
010040	01.2753	010108	01.1573	020013	00.8977	030059	01.3816
010043	00.9501	010109	01.0879	020014	00.9471	030060	01.1243
010044	00.9779	010110	00.9101	020017	01.3587	030061	01.4282
010045	01.0126	010112	01.1441	020018	00.8830	030062	01.2490
010046	01.3194	010113	01.5846	020019	00.9503	030064	01.5476
010047	00.9036	010114	01.1854	020020	00.8628	030065	01.4554
010049	01.0788	010115	00.9016	020021	00.9057	030067	01.0547
010050	00.9495	010117	01.1192	020024	01.0246	030068	01.0087
010051	00.8718	010118	01.1355	020025	01.0078	030069	01.2786
010052	00.9803	010119	01.1920	020026	01.1908	030071	00.9551
010053	01.0057	010120	00.9828	020027	00.8359	030072	00.8989
010054	01.1921	010121	01.1109	030001	01.3559	030073	01.0328
010055	01.3346	010122	00.9563	030002	01.7380	030074	01.0452
010056	01.2842	010123	01.2910	030003	01.3336	030075	00.9442
010057	01.0200	010124	01.2798	030004	00.9854	030076	01.0117
010058	00.9263	010125	01.0878	030006	01.5817	030077	00.7776
010059	00.9996	010126	01.0798	030007	01.2790	030078	01.1100
010061	00.9621	010127	01.5077	030008	01.8927	030079	00.7854
010062	00.9492	010128	00.8924	030009	01.2224	030080	01.5176
010064	01.6518	010129	01.0554	030010	01.4361	030083	01.3441

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040048	01.2069	050007	01.4703	050073	01.2120	050135	01.3049	050208	01.1976
040050	01.1109	050008	01.3953	050074	01.3076	050136	01.3076	050211	01.3168
040051	01.0280	050009	01.6000	050075	01.2731	050137	01.2767	050212	01.1095
040053	01.0717	050013	02.1120	050076	01.4954	050138	01.7096	050213	01.3564
040054	00.9446	050014	01.0900	050077	01.6483	050139	01.2205	050214	01.5716
040055	01.3252	050015	01.4684	050078	01.3238	050140	01.3019	050215	01.4204
040058	00.9180	050016	01.1946	050079	01.5241	050143	01.4009	050217	01.2056
040060	00.9695	050017	01.9933	050080	01.2311	050144	01.4930	050219	01.3706
040062	01.3526	050018	01.2796	050081	01.6282	050145	01.2900	050220	01.2450
040063	01.4390	050019	00.7922	050082	01.4809	050146	01.3049	050222	01.5296
040064	00.8984	050021	01.2764	050084	01.4872	050147	00.7747	050224	01.6173
040066	01.0283	050022	01.5545	050087	01.7521	050148	01.1390	050225	01.3297
040067	01.0036	050024	01.3828	050088	01.1315	050149	01.3558	050226	01.4251
040069	01.0551	050025	01.6798	050089	01.3407	050150	01.2390	050228	01.2661
040070	00.9657	050026	01.4721	050090	01.2425	050152	01.3970	050230	01.3292
040071	01.4155	050028	01.2747	050091	01.2298	050153	01.6477	050231	01.4958
040072	01.0725	050029	01.3320	050092	00.9567	050154	01.2110	050232	01.8455
040074	01.1757	050030	01.2945	050093	01.5271	050155	01.1197	050233	01.2228
040075	01.0993	050032	01.2717	050095	01.8435	050158	01.6379	050234	01.2798
040076	01.0551	050033	01.3884	050096	01.0718	050159	01.3837	050235	01.4968
040077	00.9291	050034	01.3070	050097	01.4338	050161	01.5294	050236	01.3888
040078	01.2401	050036	01.7045	050099	01.6542	050166	01.0654	050238	01.5071
040080	01.0646	050038	01.4082	050100	01.8331	050167	01.3999	050239	01.4064
040081	00.8575	050039	01.6461	050101	01.3574	050168	01.6888	050240	01.4360
040082	01.2094	050040	01.1045	050102	01.2827	050169	01.4921	050241	01.2925
040084	01.1260	050041	01.2924	050103	01.4956	050170	01.3981	050242	01.3955
040085	01.1257	050042	01.2177	050104	01.3491	050172	01.3240	050243	01.4729
040088	01.2212	050043	01.5692	050107	01.3433	050173	01.2573	050245	01.4000
040090	00.9494	050045	01.2626	050108	01.4305	050174	01.6003	050248	01.1513
040091	01.1566	050046	01.1808	050109	02.0924	050175	01.4063	050251	01.1670
040093	01.0247	050047	01.6987	050110	01.1464	050177	01.2293	050254	01.1327
040095	00.8694	050049	01.5231	050111	01.2808	050179	01.2228	050256	01.6656
040100	01.1223	050051	01.1343	050112	01.4457	050180	01.4073	050257	01.1369
040105	01.0147	050053	01.3009	050113	01.1647	050181	01.2654	050258	01.2623
040106	01.1790	050054	01.2674	050114	01.4614	050183	01.1410	050260	00.9203
040107	01.0462	050055	01.2734	050115	01.4725	050186	01.3155	050261	01.1843
040109	01.1371	050056	01.3617	050116	01.4336	050188	01.3896	050262	01.7410
040114	01.7026	050057	01.4453	050117	01.2996	050189	00.9187	050263	01.2486
040115	01.0629	050058	01.4042	050118	01.1611	050191	01.3865	050264	01.4191
040116	01.3681	050060	01.4612	050121	01.2872	050192	01.1849	050267	01.5161
040118	01.1909	050061	01.2545	050122	01.4208	050193	01.3445	050269	01.1058
040119	01.1355	050063	01.3401	050124	01.2011	050194	01.3361	050270	01.3105
040122	01.0989	050065	01.5135	050125	01.2949	050195	01.5421	050272	01.3153
040124	01.0864	050066	01.2789	050126	01.3888	050196	01.2815	050274	00.9881
040126	00.9696	050067	01.2843	050127	01.2533	050197	01.9226	050276	01.1377
040132	01.4616	050068	01.1129	050128	01.5007	050199	01.2776	050277	01.3979
040898	00.6959	050069	01.5887	050129	01.5397	050201	00.9026	050278	01.4018
040899	00.5933	050070	01.2006	050131	01.2597	050204	01.4002	050279	01.2294
050002	01.2983	050071	01.3234	050132	01.4007	050205	01.2271	050280	01.4564
050006	01.2943	050072	01.2213	050133	01.1959	050207	01.2364	050281	01.2638

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050282	01.2784	050366	01.2921	050446	00.8826	050535	01.3147	050607	01.2286
050283	01.4280	050367	01.2409	050447	01.0450	050537	01.2327	050608	01.1835
050286	01.0233	050369	01.2777	050448	01.0844	050539	01.2008	050609	01.2928
050289	01.6775	050373	01.3594	050449	01.2900	050541	01.4822	050613	01.0774
050290	01.4695	050376	01.3023	050450	00.7796	050542	01.1170	050615	01.3840
050291	01.1753	050377	01.0017	050451	00.9616	050543	01.3723	050616	01.3271
050292	01.1735	050378	01.1711	050454	01.6680	050545	00.9442	050618	01.1788
050293	01.2844	050379	01.1440	050455	01.8541	050546	01.0840	050619	01.3645
050295	01.3270	050380	01.6147	050456	01.3843	050547	00.9517	050622	01.0719
050296	01.1094	050382	01.4271	050457	01.8021	050549	01.7820	050623	01.1541
050298	01.2238	050385	01.3200	050458	00.9161	050550	01.1195	050624	01.2614
050299	01.2460	050387	00.9345	050459	01.2542	050551	01.2659	050625	01.4711
050300	01.2902	050388	00.9735	050464	01.7916	050552	01.0667	050630	01.2409
050301	01.1886	050390	01.2351	050467	01.2338	050557	01.5124	050633	01.2249
050302	01.2718	050391	01.4169	050468	01.6306	050559	01.2622	050635	01.2970
050305	01.4733	050392	00.9526	050469	01.0978	050560	01.2600	050636	01.2824
050307	01.4248	050393	01.5023	050470	01.1262	050561	01.1617	050637	01.1655
050308	01.5479	050394	01.4670	050471	01.7538	050564	01.3177	050638	00.9996
050309	01.2945	050396	01.5851	050476	01.2720	050565	01.1404	050641	01.1266
050310	01.2309	050397	00.8711	050477	01.3886	050566	01.0255	050643	00.9122
050312	01.7654	050401	01.2004	050478	01.0122	050567	01.6058	050644	01.1533
050313	01.1759	050404	01.0486	050481	01.4772	050568	01.3335	050649	01.3011
050315	01.2783	050406	01.0865	050482	01.0200	050569	01.2108	050651	01.2654
050317	01.2021	050407	01.1093	050483	01.2346	050570	01.6917	050655	00.7806
050320	01.3141	050410	00.8373	050485	01.7340	050571	01.4062	050660	01.1276
050324	01.8384	050411	01.3077	050486	01.4179	050573	01.6324	050661	00.8980
050325	01.2875	050414	01.2610	050488	01.2117	050575	01.2198	050662	00.8531
050327	01.6197	050417	01.1623	050489	01.0758	050577	01.3010	050663	01.0998
050328	01.2457	050418	01.3068	050491	01.4430	050578	01.4718	050666	01.0160
050329	01.2419	050419	01.2804	050492	01.2782	050579	01.4533	050667	01.0146
050331	01.2892	050420	01.3684	050494	01.0816	050580	01.2570	050668	01.1530
050333	00.9827	050421	01.3509	050496	01.7974	050581	01.3633	050669	00.7468
050334	01.4737	050423	01.0531	050497	00.7612	050583	01.7158	050670	01.2287
050335	01.2454	050424	01.6926	050498	01.1493	050584	01.2698	050671	01.1563
050336	01.2361	050425	01.3158	050502	01.6792	050585	01.3702	050672	00.6888
050337	01.2209	050426	01.3721	050503	01.2945	050586	01.3415	050674	01.1883
050342	01.3019	050427	00.9574	050506	01.4774	050587	01.2528	050675	01.4658
050343	01.0393	050430	00.9684	050510	01.2988	050588	01.2727	050676	00.9970
050345	01.3581	050431	01.0790	050512	01.2488	050589	01.3571	050677	01.2970
050348	01.7297	050432	01.6124	050515	01.3300	050590	01.3116	050678	01.1937
050349	01.0154	050433	01.0497	050516	01.3384	050591	01.1255	050680	01.1983
050350	01.4030	050434	01.1028	050517	01.3959	050592	01.2906	050682	00.9421
050351	01.4782	050435	01.2959	050522	01.3347	050593	01.2581	050684	01.2137
050352	01.2563	050436	01.0197	050523	01.2541	050594	01.9573	050685	01.1519
050353	01.6556	050438	01.4790	050526	01.3647	050597	01.3686	050686	01.2866
050355	00.9737	050440	01.2119	050527	01.2051	050598	01.3490	050688	01.1387
050357	01.8314	050441	01.7417	050528	01.2103	050599	01.6809	050689	01.3519
050359	01.1263	050442	00.8889	050530	00.9029	050601	01.3015	050690	01.1989
050360	01.4353	050443	00.9006	050531	01.2892	050603	01.4256	050691	00.9397
050363	01.3328	050444	01.2331	050534	01.4080	050604	01.4158	050693	01.2522

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050694	01.1504	060056	00.9128	070024	01.1917	100017	01.8857	100075	01.7358
050695	01.1219	060057	01.8869	070025	01.6621	100018	01.3535	100076	01.3036
050696	01.7837	060058	00.8066	070026	01.2454	100019	01.4865	100077	01.3088
050698	01.8389	060060	01.0304	070027	01.2121	100020	01.3013	100078	01.1500
050699	00.9356	060062	01.0017	070028	01.4917	100021	01.3728	100079	01.1615
050898	00.5377	060063	01.1875	070029	01.2268	100022	01.6069	100080	01.5864
050899	00.5820	060064	01.3938	070030	01.2659	100023	01.3255	100081	01.0953
060001	01.4537	060065	01.3366	070031	01.3088	100024	01.2636	100082	01.3671
060003	01.2156	060066	00.9333	070033	01.3505	100025	01.5104	100083	01.3273
060004	01.0675	060068	01.1729	070034	01.2995	100026	01.4232	100084	01.3030
060005	01.7613	060070	01.1757	070035	01.3659	100027	00.8912	100085	01.3484
060006	01.1670	060071	01.0883	070036	01.3503	100028	01.2919	100086	01.3038
060007	01.1839	060072	00.9143	070038	00.6890	100029	01.3180	100087	01.7270
060008	01.0556	060073	01.0004	070039	00.7101	100030	01.2712	100088	01.5078
060009	01.3432	060074	00.8741	070089	00.5820	100032	01.7888	100089	01.2650
060010	01.5297	060075	01.2896	080001	01.6203	100033	01.6040	100090	01.2979
060011	01.2223	060076	01.3983	080002	01.1631	100035	01.4681	100092	01.3276
060012	01.4471	060085	00.8803	080003	01.2607	100038	01.8042	100093	01.5344
060013	01.1505	060087	01.4024	080004	01.2434	100039	01.6060	100098	01.0275
060014	01.6559	060088	01.1060	080005	01.1994	100040	01.8511	100099	01.2759
060015	01.4645	060090	00.9483	080006	01.1651	100042	01.2671	100100	01.2614
060016	01.1601	060096	01.0273	080007	01.2399	100043	01.3738	100102	01.2038
060018	01.1688	060100	01.3751	080088	00.6959	100044	01.4134	100103	01.0159
060020	01.4505	060101	01.4004	080899	00.5933	100045	01.3916	100105	01.3785
060022	01.5681	060102	04.0098	090001	01.4328	100046	01.3301	100106	01.1512
060023	01.4604	060103	01.3774	090002	01.2079	100047	01.5569	100107	01.2535
060024	01.6057	060104	01.2517	090003	01.4379	100048	00.9520	100108	01.1000
060026	01.4023	070001	01.7942	090004	01.5412	100049	01.3465	100109	01.2367
060027	01.4827	070002	01.7811	090005	01.2648	100050	01.2139	100110	01.3986
060028	01.3210	070003	01.1671	090006	01.3040	100051	01.2870	100112	00.8408
060029	01.0007	070004	01.1326	090007	01.2714	100052	01.3188	100113	01.9451
060030	01.3095	070005	01.2834	090008	01.3726	100053	01.2674	100114	01.4609
060031	01.4289	070006	01.2723	090009	01.2361	100054	01.3222	100117	01.2920
060032	01.3471	070007	01.3703	090010	00.9757	100055	01.3528	100118	01.1792
060033	01.1387	070008	01.2363	090011	01.8891	100056	01.5788	100121	01.1110
060034	01.3456	070009	01.2980	090898	00.7231	100057	01.3448	100122	01.3070
060036	01.1428	070010	01.4681	090899	00.5933	100059	01.5171	100124	01.2997
060037	01.0125	070011	01.2013	100001	01.4000	100060	01.7764	100125	01.1738
060041	01.0393	070012	01.2408	100002	01.4215	100061	01.4974	100126	01.4867
060042	00.9483	070013	01.3397	100004	01.0157	100062	01.6824	100127	01.5939
060043	00.9035	070014	01.2906	100005	00.9150	100063	01.3069	100128	02.2763
060044	01.2137	070015	01.2409	100006	01.6171	100065	01.2332	100129	01.3774
060046	01.1133	070016	01.2973	100007	01.8788	100067	01.3951	100130	01.1935
060047	01.1518	070017	01.2895	100008	01.7281	100068	01.4310	100131	01.2139
060049	01.0767	070018	01.3003	100009	01.4251	100069	01.3909	100132	01.2988
060050	01.2072	070019	01.1693	100010	01.3952	100070	01.3180	100134	00.9937
060052	00.9865	070020	01.3936	100012	01.5525	100071	01.3930	100135	01.5132
060053	01.0330	070021	01.2032	100014	01.3344	100072	01.1687	100137	01.1308
060054	01.3048	070022	01.6768	100015	01.4048	100073	01.8207	100138	00.9779
		070023	01.2600	100016	01.0734	100074	01.2304	100139	01.0598

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100140	01.1109	100211	01.2754	100271	01.5410	110046	01.1827	110111	01.1528
100142	01.1554	100212	01.6385	100273	01.1315	110048	01.1312	110112	00.9332
100143	01.2493	100213	01.6171	100275	01.2908	110049	01.0813	110113	00.9359
100144	01.2342	100217	01.1825	100276	01.3876	110050	01.0816	110114	01.1564
100145	01.3950	100218	00.8936	100277	00.9858	110051	01.0597	110115	01.5940
100146	01.0733	100219	01.3936	100278	00.7001	110052	00.9588	110117	01.0856
100147	01.0822	100220	01.6915	100279	01.2487	110054	01.2304	110118	01.0237
100150	01.4413	100221	01.5388	100898	00.6949	110055	00.8773	110120	01.0427
100151	01.7316	100222	01.2115	100899	00.6006	110056	01.0010	110121	01.1165
100152	01.2547	100223	01.4299	110001	01.1521	110059	01.3460	110122	01.3175
100154	01.6119	100224	01.3205	110002	01.2100	110061	00.9824	110123	00.8407
100156	01.0572	100225	01.3552	110003	01.2807	110062	00.9283	110124	01.0701
100157	01.4940	100226	01.3232	110004	01.2335	110063	01.0237	110125	01.1454
100159	01.0483	100227	00.9987	110005	01.4139	110064	01.2407	110127	00.9562
100160	01.2020	100228	01.2815	110006	01.2835	110065	01.0074	110128	01.1585
100161	01.4972	100229	01.4520	110007	01.3649	110066	01.2501	110129	01.5776
100162	01.3005	100230	01.2915	110008	01.1195	110069	01.1877	110130	00.9831
100164	00.9793	100231	01.7215	110009	01.0965	110070	00.9533	110132	01.1265
100165	01.1584	100232	01.3052	110010	01.9743	110071	01.0251	110133	00.8840
100166	01.4862	100234	01.3446	110011	01.1453	110072	01.0014	110134	00.8867
100167	01.3312	100235	01.3244	110013	00.9995	110073	01.2412	110135	01.1890
100168	01.3000	100236	01.3262	110014	01.0751	110074	01.2548	110136	01.0683
100169	01.7889	100237	02.0913	110015	01.0547	110075	01.2140	110140	00.8759
100170	01.4209	100238	01.4063	110016	01.2469	110076	01.3555	110141	00.9009
100172	01.3702	100239	01.4274	110017	00.9250	110078	01.5980	110142	01.1020
100173	01.5692	100240	00.8782	110018	01.1500	110079	01.2995	110143	01.2729
100174	01.3602	100241	00.9973	110020	01.1531	110080	01.0573	110144	01.2323
100175	01.0959	100242	01.3171	110023	01.1880	110082	02.0469	110146	00.9212
100176	01.9604	100243	01.3904	110024	01.3752	110083	01.4836	110149	01.0848
100177	01.3378	100244	01.3450	110025	01.2755	110085	01.1704	110150	01.2289
100178	01.7123	100246	01.3711	110026	01.0967	110086	01.0771	110151	00.9758
100180	01.4072	100248	01.6901	110027	01.0378	110087	01.2536	110152	01.0233
100181	01.3175	100249	01.2950	110028	01.5517	110088	00.9038	110153	01.0138
100183	01.3326	100252	01.3833	110029	01.2996	110089	01.0962	110154	00.9353
100185	01.2225	100253	01.3613	110030	01.1911	110091	01.2709	110155	01.0543
100186	01.3573	100254	01.6178	110031	01.3097	110092	01.0621	110156	00.9178
100187	01.3150	100255	01.3761	110032	01.1164	110093	00.9371	110157	01.0763
100189	01.3593	100256	01.7248	110033	01.3355	110094	01.0178	110161	01.2627
100191	01.3654	100258	01.6866	110034	01.4077	110095	01.3290	110162	00.8182
100194	01.2560	100259	01.4085	110035	01.3190	110096	01.1582	110163	01.3511
100196	01.2443	100260	01.4028	110036	01.6238	110097	01.0965	110164	01.3161
100199	01.1796	100262	01.3321	110037	01.0704	110098	00.9990	110165	01.1867
100200	01.3590	100263	01.4506	110038	01.3240	110100	01.0918	110166	01.3448
100203	01.0913	100264	01.3849	110039	01.3166	110101	01.0179	110168	01.6530
100204	01.5664	100265	01.2832	110040	00.9159	110103	00.9408	110169	00.7644
100206	01.3601	100266	01.3117	110041	01.0693	110104	01.1343	110171	01.3323
100207	01.3742	100267	01.2275	110042	01.0518	110105	01.1652	110172	01.1520
100208	01.5110	100268	01.2570	110043	01.5543	110107	01.6078	110174	00.8696
100209	01.5225	100269	01.4176	110044	01.1345	110108	00.9078	110176	01.1254
100210	01.6631	100270	00.9092	110045	01.0129	110109	01.1161	110177	01.3896

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110178	01.2100	120899	00.5933	140008	01.4058	140070	01.2229	140132	01.5680
110179	01.1950	130001	01.1096	140010	01.3494	140072	01.1192	140133	01.3426
110181	00.8654	130002	01.3102	140011	01.0820	140074	01.1313	140135	01.2026
110183	01.3391	130003	01.2385	140012	01.2222	140075	01.3874	140137	00.9961
110184	01.1891	130005	01.3730	140013	01.3856	140077	01.2278	140138	01.0727
110185	00.9950	130006	01.6766	140014	01.0575	140078	01.2507	140139	01.0721
110186	01.2728	130007	01.4840	140015	01.2327	140080	01.8248	140140	01.0429
110187	01.1387	130008	00.8795	140016	00.9881	140081	01.1358	140141	00.9690
110188	01.3434	130009	00.9873	140018	01.4046	140082	01.2611	140143	01.0522
110189	01.0860	130010	00.9302	140019	00.9165	140083	01.2738	140144	00.9696
110190	01.1041	130011	01.3203	140024	00.9756	140084	01.1863	140145	01.0514
110191	01.1444	130012	01.0135	140025	01.1038	140086	01.1050	140146	00.9206
110192	01.3332	130013	01.2715	140026	01.1490	140087	01.3220	140147	01.1802
110193	01.2038	130014	01.2564	140027	01.0760	140088	01.4819	140148	01.5298
110194	00.9166	130015	01.0943	140029	01.3280	140089	01.2433	140150	01.3610
110195	01.0943	130016	00.8736	140030	01.5137	140090	01.3584	140151	01.0544
110196	01.3080	130017	00.9874	140031	01.0307	140091	01.6612	140152	01.0207
110200	01.7368	130018	01.5607	140032	01.2771	140093	01.2364	140154	01.2636
110201	01.2753	130019	01.1290	140033	01.2012	140094	01.2388	140155	01.2025
110202	00.8738	130021	00.8888	140034	01.1094	140095	01.2428	140158	01.4262
110203	01.0435	130022	01.1546	140035	01.0080	140097	00.9008	140159	01.1715
110204	00.9352	130024	01.1239	140036	01.1251	140098	01.3743	140160	01.1383
110205	00.9701	130025	01.0674	140037	00.9621	140100	01.2459	140161	01.1281
110206	02.6891	130026	01.1421	140038	01.0483	140101	01.0459	140162	01.4844
110207	00.9220	130027	00.8584	140039	00.9958	140102	00.9996	140164	01.2479
110208	00.9302	130028	01.2871	140040	01.2393	140103	01.3355	140165	01.0678
110209	00.7011	130029	00.9880	140041	01.0562	140105	01.2929	140166	01.2615
110210	00.5820	130030	00.9651	140042	01.0393	140107	00.9125	140167	01.0735
120001	01.6839	130031	00.9623	140043	01.1749	140108	01.1886	140168	01.2103
120002	01.1500	130034	00.9022	140045	00.9523	140109	01.1323	140170	00.9655
120003	01.0844	130035	00.9563	140046	01.1928	140110	01.2309	140171	00.8737
120004	01.2495	130036	01.1786	140047	01.0309	140112	01.0432	140172	01.5159
120005	01.2184	130037	01.4076	140048	01.2229	140113	01.3775	140173	01.0015
120006	01.2192	130039	01.1610	140049	01.3555	140114	01.2525	140174	01.3772
120007	01.5721	130040	01.0513	140051	01.2983	140115	01.1965	140176	01.2109
120008	00.8843	130043	00.9911	140052	01.2085	140117	01.2878	140177	01.2533
120010	01.5683	130044	00.9124	140053	01.7380	140118	01.4766	140179	01.2690
120011	01.2296	130045	00.9209	140054	01.3548	140119	01.6519	140180	01.4634
120012	00.9233	130048	01.0189	140055	00.9723	140120	01.1885	140181	01.3250
120014	01.1607	130049	01.1800	140058	01.0897	140121	00.9697	140182	01.3122
120015	00.9311	130051	00.9838	140059	01.0981	140122	00.9697	140184	01.1419
120016	00.9376	130054	00.9209	140061	01.0740	140123	01.3840	140185	01.4079
120018	01.0064	130056	00.9856	140062	01.2481	140124	01.1214	140186	01.2105
120019	01.1949	130058	00.9828	140063	01.3171	140125	01.2435	140187	01.4454
120021	00.9316	140001	01.2698	140064	01.1548	140126	01.6272	140188	00.9610
120022	01.5083	140002	01.2583	140065	01.3288	140128	01.2812	140189	01.1598
120025	00.9026	140003	00.9624	140066	01.2204	140129	01.1243	140190	01.1855
120026	01.2685	140004	00.9855	140067	01.6999	140128	01.1243	140191	01.4398
120027	01.3548	140005	00.9579	140068	01.1981	140129	01.0391	140192	01.1451
120898	00.7175	140007	01.2724	140069	01.0660	140130	01.1338	140193	00.9858

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140197	01.2882	140294	01.0919	150049	01.0924	150106	01.0668	160035	00.9368
140199	01.0106	140295	03.2088	150050	01.1859	150109	01.2650	160036	01.0395
140200	01.4366	140297	01.4210	150051	01.2452	150110	00.8976	160037	01.0143
140202	01.2227	140299	00.8993	150052	01.0428	150111	01.0917	160039	01.0458
140203	01.1278	140898	00.8924	150053	01.0452	150112	01.1989	160040	01.3641
140205	00.9527	140899	00.6352	150054	01.0374	150113	01.2254	160041	01.1105
140206	01.0917	150001	01.0872	150056	01.6681	150114	01.0604	160043	00.9607
140207	01.2752	150002	01.3396	150057	02.2248	150115	01.2862	160044	01.2347
140208	01.4301	150003	01.6335	150058	01.5514	150122	01.0811	160045	01.6083
140209	01.5796	150004	01.3049	150059	01.2200	150123	00.9500	160046	01.0233
140210	01.0418	150005	01.2120	150060	01.1691	150124	01.1757	160047	01.4117
140211	01.1430	150006	01.2427	150061	01.1915	150125	01.3902	160048	01.0463
140212	01.2923	150007	01.1958	150062	01.0878	150126	01.5391	160049	00.8896
140213	01.1891	150008	01.3471	150063	01.1266	150127	01.1255	160050	01.0356
140215	01.0481	150009	01.2883	150064	01.0547	150128	01.1864	160051	01.2980
140217	01.2404	150010	01.1807	150065	01.1110	150129	01.2885	160052	00.9752
140218	00.9903	150011	01.2480	150066	01.1229	150130	01.1040	160054	01.0605
140220	01.1380	150012	01.5707	150067	01.0802	150132	01.3875	160055	01.0045
140223	01.5097	150013	01.1969	150069	01.2349	150133	01.2524	160056	01.0432
140224	01.3237	150014	01.3615	150070	01.0952	150134	01.1594	160057	01.3504
140226	00.9496	150015	01.2205	150071	01.1539	150135	00.8938	160058	01.6167
140228	01.5284	150017	01.6692	150072	01.2502	150136	01.0712	160059	01.2381
140229	00.9591	150018	01.2400	150073	01.0557	150898	00.7260	160060	01.0618
140230	00.9458	150019	01.1684	150074	01.4864	150899	00.5933	160061	00.9354
140231	01.5632	150020	01.1266	150075	01.2370	160001	01.1451	160062	00.9270
140233	01.6567	150021	01.6148	150076	01.0498	160002	01.2223	160063	01.1758
140234	01.1265	150022	01.1076	150077	01.1775	160003	01.0648	160064	01.5209
140236	00.9971	150023	01.3818	150078	01.0640	160005	01.0807	160065	01.1123
140239	01.5826	150024	01.1843	150079	01.1552	160007	00.9657	160066	01.0604
140240	01.2535	150025	01.5039	150082	01.3845	160008	01.0890	160067	01.2617
140242	01.4080	150026	01.1843	150084	01.6812	160009	01.1263	160068	01.0560
140245	01.0274	150027	01.0029	150085	00.9948	160012	01.1684	160069	01.3498
140246	01.0311	150029	01.2353	150086	01.2483	160013	01.2530	160070	01.1060
140250	01.2363	150030	01.1539	150088	01.1363	160014	00.9618	160071	01.1144
140251	01.3085	150031	01.0706	150089	01.2738	160016	01.2818	160072	01.0518
140252	01.2863	150032	01.6930	150090	01.2715	160018	00.9819	160073	00.8924
140253	01.2931	150033	01.5659	150091	01.2111	160020	01.0939	160074	01.0304
140258	01.3979	150034	01.3002	150092	01.1645	160021	01.1478	160075	01.0803
140271	01.0344	150035	01.4019	150094	01.0414	160023	01.0621	160076	00.9634
140275	01.1770	150036	01.0040	150095	01.1058	160024	01.4469	160077	01.1095
140276	02.0385	150037	01.2103	150096	00.9957	160025	01.8041	160079	01.2857
140280	01.1551	150038	01.2428	150097	01.0367	160026	01.0311	160080	01.1228
140281	01.5138	150039	00.9885	150098	01.0378	160027	01.1356	160081	01.0751
140285	01.2667	150042	01.1889	150099	01.2905	160028	01.2583	160082	01.6686
140286	01.1118	150043	01.0630	150100	01.6108	160029	01.4707	160083	01.5523
140288	01.5938	150044	01.2287	150101	01.0723	160030	01.3123	160085	01.1194
140289	01.2903	150045	01.1566	150102	01.1110	160031	01.0370	160086	01.0224
140290	01.3760	150046	01.4038	150103	01.1377	160032	01.0520	160088	01.0071
140291	01.2686	150047	01.6561	150104	01.1765	160033	01.3371	160089	01.2042
140292	01.1829	150048	01.1894	150105	01.1899	160034	01.0069	160090	01.0612

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160091	01.1484	170001	01.1766	170060	01.0271	170119	00.9660	180014	01.5682
160092	00.9577	170003	01.1989	170061	00.9579	170120	01.2204	180015	01.1127
160093	01.1072	170004	01.0516	170062	00.8377	170121	00.7809	180016	01.2169
160094	01.1693	170006	01.2448	170063	00.9206	170122	01.7991	180017	01.2192
160095	01.0180	170007	01.1010	170064	01.1751	170123	01.6654	180018	01.1517
160097	01.1539	170008	00.9991	170066	00.9209	170124	00.9671	180019	01.1733
160098	00.9540	170009	01.1522	170067	01.0420	170125	00.9370	180020	01.0135
160099	01.1000	170010	01.1259	170068	01.2396	170126	00.9444	180021	00.8932
160101	01.1539	170011	01.3697	170069	00.8692	170128	00.9867	180023	00.8378
160102	01.4277	170012	01.4225	170070	01.0520	170131	01.1211	180024	01.1971
160103	00.9088	170013	01.2044	170072	00.9388	170133	01.1665	180025	01.1364
160104	01.1289	170014	01.0518	170073	01.1051	170134	00.9839	180026	01.1047
160106	01.0244	170015	01.0848	170074	01.1606	170137	01.1593	180027	01.1584
160107	01.1155	170016	01.5595	170075	00.8531	170139	00.9930	180028	00.9983
160108	01.1355	170017	01.1637	170076	01.1126	170140	01.0413	180029	01.2807
160109	00.9404	170018	01.0952	170077	00.9616	170142	01.2571	180030	01.1426
160110	01.5133	170019	01.1744	170079	00.9817	170143	01.0974	180031	01.0072
160111	01.1219	170020	01.2290	170080	00.9380	170144	01.4918	180032	00.9826
160112	01.3817	170021	00.8715	170081	01.1493	170145	01.1412	180033	01.0839
160113	01.0406	170022	01.1905	170082	00.9060	170146	01.3039	180034	01.0142
160114	00.9999	170023	01.3064	170084	00.9248	170147	01.2069	180035	01.4414
160115	01.0056	170024	01.1095	170085	00.9504	170148	01.3398	180036	01.1078
160116	01.1577	170025	01.4207	170086	01.6370	170150	01.1203	180037	01.2749
160117	01.3154	170026	00.9821	170087	01.3418	170151	01.0078	180038	01.3275
160118	00.9818	170027	01.1582	170088	00.9179	170152	00.9171	180040	01.9553
160119	00.8638	170030	00.9603	170089	01.0088	170159	00.9069	180041	01.0752
160120	01.0027	170031	00.8710	170090	00.9886	170160	00.9558	180042	01.0414
160122	01.2211	170032	01.0511	170092	00.8533	170164	01.0932	180043	01.0160
160123	01.0925	170033	01.2049	170093	01.0010	170166	01.0040	180044	01.0751
160124	01.1718	170034	00.9479	170094	01.0075	170168	00.8770	180045	01.1608
160126	01.1321	170035	00.8775	170095	01.1793	170170	00.8764	180046	01.0588
160129	01.1705	170036	00.9422	170097	00.9444	170171	01.1352	180047	01.0240
160130	01.2416	170037	01.1652	170098	01.0209	170172	01.0228	180048	01.2059
160131	01.1606	170038	01.0037	170099	01.3717	170173	00.8102	180049	01.3416
160133	01.2038	170039	01.1149	170100	00.8651	170174	00.9340	180050	01.3005
160134	00.8828	170040	01.4016	170101	00.9907	170175	01.2210	180051	01.2125
160135	01.0239	170041	01.0179	170102	00.9830	170176	01.4211	180053	01.1658
160138	01.1582	170043	01.0588	170103	01.2192	170178	00.7011	180054	01.0992
160140	01.0684	170044	01.2595	170104	01.4420	170179	00.5933	180055	01.0622
160141	00.9181	170045	01.0009	170105	00.8777	180001	01.1568	180056	01.0495
160142	01.1483	170049	01.3135	170106	00.8914	180002	01.1128	180058	00.9086
160143	01.1009	170050	00.9428	170108	00.8933	180004	01.1876	180059	00.9006
160145	00.9850	170051	00.9672	170109	01.0060	180005	01.0678	180060	00.9007
160146	01.3144	170052	01.1010	170110	00.9566	180006	00.9384	180062	00.8038
160147	01.2240	170053	00.8500	170112	00.9259	180007	01.4138	180063	01.0339
160151	01.1435	170054	01.0908	170113	01.0555	180009	01.1713	180064	01.0689
160152	01.0277	170055	01.0664	170114	01.0676	180010	01.7280	180065	00.9945
160153	01.5615	170056	00.9870	170115	01.0850	180011	01.1112	180066	01.1178
160888	00.6959	170057	01.0294	170116	01.1178	180012	01.2604	180067	01.8949
160899	00.5933	170058	01.0300	170117	00.9506	180013	01.3284	180069	01.0734

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 19--

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180070	01.0604	190005	01.3286	190089	01.0615	190166	01.0025	200021	01.1379
180072	01.0944	190006	01.1351	190090	01.1961	190167	01.2923	200023	00.7985
180075	00.9469	190007	01.0395	190092	01.1582	190170	00.9991	200024	01.1779
180078	01.0119	190008	01.4417	190095	01.0340	190173	01.4355	200025	01.1393
180079	01.0166	190009	01.0851	190098	01.3985	190175	01.8435	200026	00.9960
180080	01.1256	190010	00.9175	190099	01.1843	190176	01.4068	200027	01.0935
180081	01.3824	190011	01.0666	190102	01.4389	190177	01.4835	200028	01.0334
180085	01.3287	190013	01.2161	190103	00.8983	190178	00.9782	200031	01.2861
180087	00.9932	190014	00.9911	190106	01.1573	190182	01.0127	200032	01.2792
180088	01.6306	190015	01.1926	190109	01.0888	190183	01.0827	200033	01.6831
180092	01.1195	190017	01.2253	190110	00.9559	190184	00.9057	200034	01.1862
180093	01.3949	190018	01.1571	190111	01.5694	190185	01.2344	200037	01.1597
180094	00.9899	190019	01.4998	190112	01.2864	190186	00.9483	200038	00.9975
180095	00.9747	190020	01.1555	190113	01.2797	190187	00.6412	200039	01.3035
180099	00.9687	190023	00.6808	190114	00.9308	190189	01.0911	200040	01.0475
180101	01.2636	190025	01.2536	190115	01.2953	190190	00.9922	200041	01.1668
180102	01.3971	190026	01.3165	190116	01.2228	190191	01.2162	200043	00.6671
180103	01.7927	190027	01.3975	190118	00.9961	190193	01.1742	200044	01.1565
180104	01.3910	190029	01.2529	190120	00.9064	190194	01.1284	200050	01.1171
180105	00.9748	190033	00.9707	190122	01.1329	190196	00.8243	200051	00.9904
180106	00.9035	190034	01.2313	190124	01.4467	190197	01.1989	200052	01.0218
180108	00.9010	190035	01.3875	190125	01.3914	190198	01.1858	200055	01.0384
180115	00.9740	190036	01.6287	190127	01.4598	190199	01.2694	200062	00.9684
180116	01.2751	190037	00.9902	190128	00.8313	190200	01.5712	200063	01.2180
180117	01.2463	190039	01.4272	190130	00.9233	190201	01.2069	200066	01.1416
180118	01.0101	190040	01.3613	190131	01.2752	190202	01.4032	200088	00.7186
180120	00.9151	190041	01.5707	190132	01.0494	190203	01.6151	200089	00.5933
180121	01.0529	190043	01.0441	190133	01.0812	190204	01.4464	210001	01.3187
180122	00.9415	190044	01.0906	190134	01.0061	190205	01.3525	210002	01.8268
180123	01.4435	190045	01.2700	190135	01.3432	190206	01.4626	210003	01.3868
180124	01.3284	190046	01.4261	190136	01.0332	190207	01.1786	210004	01.2835
180125	01.0292	190047	01.1475	190138	00.7637	190208	00.8766	210005	01.2017
180126	01.0501	190048	00.9763	190140	01.0116	190211	00.8754	210006	01.0687
180127	01.1553	190049	00.9837	190142	00.9468	190212	00.8972	210007	01.4397
180128	01.1060	190050	01.0296	190144	01.1462	190213	00.8023	210008	01.2563
180129	01.0536	190053	01.0184	190145	00.9264	200001	01.3043	210009	01.6435
180130	01.3800	190054	01.3946	190146	01.4517	200002	01.0658	210010	01.1370
180132	01.3111	190059	00.9436	190147	00.9622	200003	01.0435	210011	01.2905
180133	01.2224	190060	01.2386	190148	00.9443	200006	01.0569	210012	01.4621
180134	01.0785	190064	01.4479	190149	00.9865	200007	01.0301	210013	01.3075
180136	01.2725	190065	01.4536	190151	01.0819	200008	01.2185	210015	01.1962
180137	01.7633	190071	00.8966	190152	01.4090	200009	01.6646	210016	01.7570
180138	01.2008	190075	01.4308	190155	00.9290	200012	01.1761	210017	01.1492
180139	01.0218	190077	00.8858	190156	00.8485	200013	01.0999	210018	01.2185
180140	00.7011	190078	01.1560	190158	01.2945	200015	01.2713	210019	01.3370
180888	00.5933	190079	01.2140	190160	01.1171	200016	01.0251	210021	01.2287
190001	00.9031	190081	00.8842	190161	00.8602	200017	01.3000	210022	01.3076
190002	01.5748	190083	00.8864	190162	01.2684	200018	01.1012	210023	01.2875
190003	01.3824	190086	01.2301	190164	01.0616	200019	01.2191	210024	01.2470
190004	01.1594	190088	01.3339	190165	01.0990	200020	01.0770	210025	01.2665

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
210026	01.3399	220030	01.0759	220100	01.2685	230027	01.0726	230099	01.2165
210027	01.1915	220031	01.7720	220101	01.3751	230029	01.4937	230100	01.1909
210028	01.0603	220033	01.2325	220102	00.8471	230030	01.1900	230101	01.0486
210029	01.3483	220035	01.1796	220104	01.2517	230031	01.3663	230103	01.0063
210030	01.0737	220036	01.4857	220105	01.1727	230032	01.6988	230104	01.5840
210031	01.4343	220038	01.2594	220106	01.1047	230034	01.1813	230105	01.5840
210032	01.2017	220041	01.1651	220107	01.1484	230035	01.1610	230106	01.1158
210033	01.1315	220042	01.1582	220108	01.1408	230036	01.2927	230107	00.9927
210034	01.1957	220045	01.1922	220110	01.9242	230037	01.2618	230108	01.1927
210035	01.1516	220046	01.3649	220111	01.1749	230038	01.5814	230110	01.2233
210036	01.2090	220048	01.1731	220114	01.0691	230039	01.2706	230111	01.0531
210037	01.1963	220049	01.1770	220115	01.2586	230040	01.3094	230113	01.0332
210038	01.3690	220050	00.9935	220116	01.7808	230041	01.1244	230114	00.7155
210039	01.2111	220051	01.2231	220118	01.9184	230042	01.0922	230115	01.0247
210040	01.3483	220052	01.2324	220119	01.3480	230046	01.7778	230116	00.8996
210043	01.1912	220053	01.2759	220120	00.9897	230047	01.2132	230117	01.8012
210044	01.1947	220055	01.1790	220123	00.9544	230053	01.4582	230118	01.2633
210045	00.9711	220057	01.1952	220126	01.2221	230054	01.6087	230119	01.2036
210046	01.1133	220058	01.0110	220128	01.1054	230055	01.1378	230120	01.0488
210048	01.1709	220060	01.1410	220131	01.1603	230056	00.9746	230121	01.2042
210049	01.1592	220062	00.6506	220133	00.8198	230058	01.1557	230122	01.3546
210051	01.3069	220063	01.1302	220135	01.1201	230059	01.4298	230124	01.1293
210054	01.2430	220064	01.1842	220153	01.0533	230060	01.1575	230125	01.3861
210055	01.1873	220065	01.1730	220154	00.9739	230062	01.1168	230128	01.3852
210056	01.3827	220066	01.2844	220156	01.2135	230063	01.2740	230129	01.8948
210057	01.2412	220067	01.2421	220162	01.4141	230065	01.4458	230130	01.5769
210058	01.7326	220068	00.6158	220163	01.9524	230066	01.3086	230132	01.3555
210059	01.3338	220070	01.1448	220171	01.6218	230068	01.3535	230133	01.1355
210060	01.0691	220071	01.8433	220173	00.4926	230069	01.0882	230134	01.3103
220001	01.1452	220073	01.2256	220175	01.0281	230070	01.3145	230135	01.3091
220002	01.3378	220074	01.1306	220897	05.1063	230071	00.6451	230137	01.0714
220003	01.1019	220075	00.7660	220898	00.7055	230072	01.1737	230138	00.8905
220004	01.3471	220076	01.1958	220899	00.5933	230075	01.3005	230140	01.5729
220006	01.2662	220077	01.6055	230001	01.1368	230076	01.2066	230141	01.5224
220008	01.1510	220079	01.1158	230002	01.2313	230077	02.1526	230142	01.2201
220010	01.1982	220080	01.1925	230003	01.1349	230078	01.3371	230143	01.2272
220011	01.1712	220081	00.9674	230004	01.7077	230080	01.2354	230144	01.1998
220012	01.1800	220082	01.2243	230005	01.2118	230081	01.1767	230145	01.1053
220015	01.2004	220083	01.1209	230006	00.9919	230082	01.1676	230146	01.2260
220016	01.1906	220084	01.1424	230007	01.0868	230085	01.1435	230147	01.5011
220017	01.2497	220086	01.5547	230012	00.8113	230086	00.9529	230149	01.0477
220019	01.0969	220088	01.4865	230013	01.2918	230087	01.1429	230150	01.5926
220020	01.1520	220089	01.2757	230014	00.9400	230089	01.3407	230151	01.3913
220021	01.2291	220090	01.1721	230015	01.3911	230090	01.2163	230153	01.0626
220023	01.2605	220092	01.1975	230017	01.5372	230092	01.2598	230154	01.1020
220024	01.1963	220094	01.2036	230019	01.5695	230093	01.1943	230155	01.0461
220025	01.0212	220095	01.1863	230020	01.5820	230095	01.1378	230156	01.6427
220026	01.2735	220097	01.0102	230021	01.5274	230096	01.0961	230157	01.3922
220028	01.4023	220098	01.2922	230022	01.2625	230097	01.5044	230159	01.3484
220029	01.1179	220099	01.1357	230024	01.4735	230098	00.7519	230162	00.9254

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230165	01.7088	230259	01.0814	240050	01.1246	240111	01.0053
230167	01.1964	230264	01.3379	240051	00.8788	240112	01.0203
230169	01.3236	230266	01.3527	240052	01.2180	240114	01.0895
230171	01.1730	230269	01.2338	240053	01.4600	240115	01.5260
230172	01.1684	230270	01.2680	240056	01.3083	240116	00.9281
230173	01.4305	230273	01.4920	240057	01.7598	240117	01.1230
230174	01.2339	230275	00.7517	240058	00.9866	240119	00.9196
230175	01.0288	230276	01.0259	240059	01.1126	240121	00.9339
230176	01.1450	230277	01.1410	240061	01.4280	240122	01.0881
230178	01.1113	230278	01.4955	240063	01.5098	240123	01.1306
230179	00.8224	230888	00.7113	240064	01.2314	240124	01.0103
230180	01.1210	230899	00.6096	240065	00.9942	240125	00.9385
230184	01.1455	240001	01.5487	240066	01.3506	240127	01.0661
230186	01.0154	240002	01.6757	240069	01.1869	240128	01.1584
230188	01.1331	240003	01.2466	240071	01.1155	240129	00.9601
230189	00.9138	240004	01.4783	240072	00.9939	240130	01.0192
230190	00.9790	240005	00.9433	240073	01.0033	240132	01.2909
230191	00.9616	240006	01.1764	240075	01.2355	240133	01.1252
230193	01.3041	240007	01.1059	240076	01.1264	240134	01.0216
230194	01.2159	240008	01.0324	240077	01.0247	240135	00.8382
230195	01.3667	240009	01.0705	240078	01.3836	240136	00.8763
230197	01.2310	240010	01.8486	240079	01.0791	240137	01.1818
230199	01.1837	240011	01.0393	240080	01.3605	240138	00.8802
230201	00.9747	240013	01.2251	240082	01.1982	240139	00.9800
230204	01.2507	240014	01.1819	240083	01.2390	240140	00.8296
230205	01.1182	240016	01.3521	240084	01.2448	240141	01.0087
230207	01.2930	240017	01.1897	240085	00.8683	240142	01.0533
230208	01.0780	240018	01.2161	240086	01.0726	240143	00.9570
230211	00.9553	240019	01.3366	240087	01.0552	240144	00.9825
230212	01.0852	240020	01.2241	240088	01.4404	240145	00.9147
230213	01.0959	240021	01.0442	240089	01.0130	240146	00.9886
230216	01.3120	240022	01.0947	240090	01.0246	240148	00.9878
230217	01.0827	240023	01.0434	240091	00.9799	240150	00.9497
230219	01.0083	240025	01.1964	240093	01.2910	240152	00.9632
230221	01.2415	240027	01.0586	240094	00.9949	240153	00.9833
230222	01.3501	240028	01.1193	240096	01.0553	240154	00.9785
230223	01.2913	240029	01.1741	240097	01.0524	240155	00.9636
230227	01.3514	240030	01.3263	240098	00.9298	240156	01.0391
230228	01.1930	240031	00.9580	240099	00.9524	240157	01.0666
230230	01.3405	240036	01.4943	240100	01.3042	240158	00.9179
230232	01.0412	240037	01.0507	240101	01.2096	240160	00.9688
230235	00.9867	240038	01.4615	240102	01.0953	240161	00.9893
230236	01.3399	240040	01.2780	240103	01.1664	240162	01.0592
230237	01.0889	240041	01.2177	240104	01.2187	240163	00.9659
230239	01.1560	240043	01.1255	240105	00.8992	240166	01.1525
230241	01.2143	240044	01.1644	240106	01.3209	240167	00.8388
230244	01.3681	240045	01.1021	240107	00.9677	240169	00.9684
230253	01.1032	240047	01.3887	240108	00.9392	240170	01.0584
230254	01.2625	240048	01.2591	240109	00.9691	240171	01.0991
230257	00.9162	240049	01.6577	240110	01.0154	240172	01.0845

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
250037	00.8930	250101	00.8326	260021	01.2831	260089	01.0829	260176	01.4620
250038	00.9187	250102	01.4419	260022	01.3869	260090	01.4544	260177	01.3048
250039	01.0118	250104	01.3143	260023	01.2732	260091	01.5467	260178	01.4142
250040	01.2053	250105	00.9087	260024	01.0607	260092	01.1280	260179	01.5442
250042	01.1271	250107	00.9189	260025	01.3033	260094	01.0700	260180	01.5485
250043	00.8909	250109	00.9056	260026	00.9474	260095	01.3661	260182	01.0209
250044	01.0525	250112	00.9541	260027	01.5417	260096	01.4280	260183	01.4446
250045	01.1647	250113	00.9556	260029	01.1609	260097	01.1961	260186	01.1420
250046	01.0475	250117	01.0380	260030	01.1169	260100	01.1503	260188	01.1727
250047	00.9326	250119	00.9667	260031	01.4544	260102	00.9735	260189	00.9530
250048	01.3353	250120	01.0662	260032	01.6111	260103	01.3136	260190	01.1426
250049	00.9272	250122	01.2651	260033	01.2668	260104	01.6018	260191	01.2506
250050	01.1693	250123	01.1486	260034	01.0358	260105	01.3059	260193	01.2130
250051	00.8808	250124	00.8813	260035	01.0577	260107	01.3046	260195	01.1116
250057	01.0880	250125	01.2550	260036	01.0900	260108	01.6531	260197	01.2125
250058	01.1730	250126	00.9918	260037	01.2409	260109	00.9896	260198	01.2873
250059	01.0052	250127	00.8436	260039	01.2995	260110	01.6543	260200	01.1639
250060	00.8007	250128	00.9709	260040	01.4981	260111	00.9715	260202	01.3792
250081	00.9120	250129	01.1736	260042	01.1125	260112	01.4243	260898	00.6959
250062	00.9942	250131	00.9613	260044	01.0607	260113	01.1687	260899	00.5933
250063	00.8561	250134	00.9535	260047	01.3407	260115	01.0292	270002	01.2268
250065	00.9442	250136	00.7432	260048	01.3525	260116	01.2167	270003	01.2111
250066	00.9378	250137	00.9631	260049	00.9763	260119	01.1453	270004	01.6654
250067	01.0105	250138	01.3198	260050	01.0947	260120	01.1658	270006	00.8607
250068	00.8515	250139	00.9033	260051	01.2169	260122	01.2201	270007	00.9635
250069	01.2290	250140	00.8149	260052	01.1899	260123	00.9644	270009	01.0755
250071	01.0512	250141	01.1843	260053	01.0725	260127	01.1482	270011	01.1328
250072	01.2240	250142	00.7975	260054	01.3329	260128	01.0252	270012	01.3842
250073	00.9892	250143	00.9179	260055	01.2043	260129	01.0795	270013	01.2712
250076	00.9129	250898	00.7011	260057	01.1640	260131	01.3650	270014	01.6252
250077	00.9331	250899	00.5933	260059	01.0850	260134	01.2778	270016	00.8858
250078	01.3886	260001	01.5613	260061	01.1065	260137	01.2258	270017	01.1953
250079	00.8598	260002	01.3257	260062	01.1663	260138	01.8004	270019	00.9792
250081	01.2215	260003	00.9540	260063	01.1723	260141	02.0416	270021	01.0883
250082	01.2514	260004	01.0358	260064	01.3736	260142	01.2080	270023	01.3089
250083	00.8897	260005	01.3728	260065	01.6066	260143	01.1436	270024	01.0469
250084	01.1966	260006	01.3907	260066	01.0404	260146	01.3910	270026	00.9326
250085	01.0008	260007	01.2514	260067	00.9180	260147	01.0426	270027	01.0139
250086	00.9265	260008	01.1982	260068	01.7883	260148	01.0995	270028	01.0329
250088	01.0092	260009	01.2630	260070	01.0768	260153	01.1385	270029	01.0812
250089	00.9999	260011	01.5392	260073	00.9728	260159	01.1010	270030	00.9514
250091	01.0206	260012	01.0056	260074	01.1957	260160	01.1248	270031	00.8901
250093	01.1580	260013	01.1565	260077	01.3904	260162	01.0112	270032	01.1279
250094	01.2725	260014	01.6238	260078	01.1134	260163	01.2131	270033	00.8346
250095	01.0480	260015	01.1876	260079	01.0053	260164	01.0592	270035	01.0460
250096	01.1992	260016	01.2309	260080	01.1100	260165	00.9779	270036	00.9983
250097	01.1853	260017	01.2115	260081	01.4046	260166	01.2324	270039	00.9205
250098	00.8454	260018	00.9483	260082	01.1548	260172	01.0210	270040	01.0094
250099	01.2061	260019	01.0160	260085	01.4457	260173	01.0721	270041	00.9284
250100	01.1505	260020	01.6168	260086	01.0581	260175	01.1367	270044	01.1145

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
270046	00.9532	280031	01.1045	280092	00.9934	300008	01.2355	310032	01.2549
270047	00.9928	280032	01.1851	280094	01.1222	300009	01.2220	310034	01.1526
270048	01.1120	280033	00.9335	280097	00.8690	300010	01.2353	310036	01.2028
270049	01.5750	280034	01.2721	280098	01.0099	300011	01.2187	310037	01.2170
270050	01.0269	280035	00.9044	280101	01.1203	300012	01.2576	310038	01.6843
270051	01.1910	280037	00.9497	280102	00.8643	300013	01.1540	310039	01.2925
270052	01.0407	280038	01.0366	280104	00.9322	300014	01.3466	310040	01.2080
270053	00.9047	280039	01.0737	280105	01.2152	300015	01.0421	310041	01.2512
270055	00.6803	280040	01.5666	280106	01.0201	300016	01.2323	310042	01.1506
270057	01.1117	280041	00.9218	280107	01.0745	300017	01.2003	310043	01.2114
270058	00.9434	280042	00.9783	280108	01.0455	300018	01.2254	310044	01.2584
270059	00.8462	280043	01.1572	280109	00.8824	300019	01.2697	310045	01.2746
270060	00.9544	280045	01.1270	280110	00.9953	300020	01.1540	310047	01.2626
270063	00.8769	280046	01.0164	280111	01.1938	300021	01.1536	310048	01.2321
270067	00.9538	280047	01.1721	280114	00.9322	300022	01.1215	310049	01.2456
270068	00.8818	280048	01.0670	280115	00.9657	300023	01.2290	310050	01.1909
270072	00.8453	280049	01.0303	280117	01.0890	300024	01.2535	310051	01.2915
270073	01.2183	280050	00.9881	280118	01.0141	300028	01.1845	310052	01.1763
270074	00.8436	280051	00.9674	280119	00.9109	300029	01.2856	310054	01.1859
270075	00.9671	280052	01.0106	280123	00.9142	300033	01.0735	310056	01.2249
270076	00.8432	280054	01.1549	280898	00.7011	300034	01.7411	310057	01.1769
270079	00.9286	280055	00.9710	280899	00.5933	300898	00.7055	310058	01.2048
270080	01.1143	280056	00.9827	290001	00.9406	310001	01.6578	310061	01.1485
270081	00.9430	280057	01.0219	290002	00.8362	310002	01.8335	310062	01.1534
270082	00.9041	280058	01.2317	290003	01.1879	310003	01.2124	310063	01.3049
270083	00.9864	280060	01.4590	290005	01.0956	310005	01.2569	310064	01.2228
270084	00.9482	280061	01.2910	290006	01.0956	310006	01.1516	310067	01.2307
270898	00.7166	280062	01.1223	290007	01.7005	310008	01.3109	310069	01.1381
270899	00.5933	280064	01.0678	290008	01.2704	310009	01.1789	310070	01.2633
280001	01.1182	280065	01.1466	290009	01.5518	310010	01.2440	310071	00.9062
280003	01.8260	280066	01.1535	290010	01.0426	310011	01.2175	310072	01.2813
280005	01.4500	280068	00.9262	290011	01.0069	310012	01.5288	310073	01.4049
280009	01.4855	280070	00.9697	290012	01.3145	310013	01.2615	310074	01.2930
280011	00.9936	280073	00.9619	290013	01.0691	310014	01.5702	310075	01.2412
280012	01.9172	280074	01.1627	290014	00.9938	310015	01.5962	310076	01.3239
280013	01.9172	280075	01.2967	290015	01.0594	310016	01.2386	310077	01.5759
280014	00.9868	280076	00.9741	290016	01.2354	310017	01.3287	310078	01.2965
280015	01.0075	280077	01.2704	290018	01.0306	310018	01.2118	310081	01.1964
280017	01.1621	280078	00.9440	290019	01.2083	310019	01.6564	310083	01.2911
280018	00.9322	280079	00.9652	290020	01.0173	310020	01.1989	310084	01.2308
280020	01.4323	280080	01.0670	290021	01.5430	310021	01.2415	310085	01.2262
280021	01.1422	280081	01.4435	290022	01.6758	310022	01.2106	310086	01.1769
280022	01.0214	280082	01.4939	290027	00.9600	310024	01.2169	310087	01.1864
280023	01.3568	280083	00.9711	290029	00.7746	310025	01.1601	310088	01.2569
280024	00.8310	280084	00.9581	290032	01.4420	310026	01.2314	310090	01.2539
280025	00.9937	280085	00.9546	300001	01.2914	310027	01.2724	310091	01.2398
280026	01.0445	280088	01.8300	300003	01.8799	310028	01.1847	310092	01.3387
280028	00.8807	280089	01.3445	300005	01.3445	310029	01.8190	310093	01.0833
280029	01.0108	280090	00.9305	300006	01.1117	310031	02.7545	310096	01.7282
280030	01.7771	280091	01.0154	300007	01.1003				

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
310105	01.0944	320057	00.8602	330053	01.0513	330127	01.2252	330201	01.4914
310108	01.3596	320058	00.8736	330055	01.3973	330128	01.4005	330202	01.2794
310110	01.2095	320059	01.0429	330056	01.4060	330132	01.1135	330203	01.4157
310111	01.2331	320070	00.9856	330057	01.5811	330133	01.2789	330204	01.2648
310112	01.2160	320072	01.5919	330058	01.3020	330135	01.1790	330205	01.0993
310113	01.2212	320074	01.0663	330059	01.4747	330136	01.2399	330206	01.1781
310115	01.1844	320076	01.1175	330061	01.3031	330140	01.6372	330209	01.2066
310116	01.2549	320079	01.0770	330062	01.0569	330141	01.2477	330211	01.2290
310118	01.1946	320088	00.7241	330064	01.2798	330142	01.3141	330212	01.2391
310119	01.5145	320089	00.5933	330065	01.1733	330144	01.0037	330213	01.1508
310120	01.0583	330001	01.1560	330066	01.2167	330148	01.0177	330214	01.1746
310121	01.0506	330002	01.4240	330067	01.3164	330151	01.1024	330215	01.1883
310898	00.7011	330003	01.3300	330072	01.3217	330152	01.4034	330218	01.2156
310899	00.5820	330004	01.3071	330073	01.1219	330153	01.3076	330219	01.5641
320001	01.4300	330005	01.6638	330074	01.2650	330154	01.3975	330221	01.2786
320002	01.2442	330006	01.3572	330075	01.0670	330155	01.1739	330222	01.2062
320003	01.1382	330007	01.3469	330078	01.3601	330157	01.3135	330223	01.0765
320004	01.1776	330008	01.1911	330079	01.1014	330158	01.3151	330224	01.2649
320005	01.2389	330009	01.3027	330080	01.2452	330159	01.2782	330225	01.1733
320006	01.1944	330010	01.2150	330082	01.2209	330160	01.4381	330226	01.2993
320009	01.3505	330011	01.1975	330084	00.9667	330161	01.0558	330229	01.1804
320011	00.9584	330012	01.5788	330085	01.3318	330162	01.2408	330230	01.4463
320012	00.9736	330013	02.0376	330086	01.2710	330163	01.1750	330231	01.2100
320013	01.0998	330014	01.3760	330088	01.0905	330164	01.3939	330232	01.2402
320014	00.9454	330015	00.8720	330090	01.7340	330166	00.9389	330233	01.5026
320016	01.2056	330016	00.9942	330091	01.3319	330167	01.5214	330234	01.8929
320017	01.2002	330019	01.3449	330092	00.9838	330169	01.3728	330235	01.1854
320018	01.2417	330020	00.9904	330094	01.3141	330171	01.2915	330236	01.3596
320019	01.3538	330022	01.0132	330095	01.2325	330174	00.7840	330238	01.1009
320021	01.6441	330023	01.2086	330096	01.1394	330175	01.0503	330239	01.1613
320022	01.2261	330024	01.6925	330097	01.1737	330176	00.8622	330240	01.3378
320023	01.1057	330025	01.1062	330100	00.6809	330177	01.0684	330241	01.7452
320030	01.0421	330027	01.4311	330101	01.6650	330179	00.9373	330242	01.2437
320031	00.9598	330028	01.3321	330102	01.2920	330180	01.2225	330244	01.0699
320032	00.9241	330029	01.1444	330103	01.1701	330181	01.2585	330245	01.3008
320033	01.0992	330030	01.1690	330104	01.3306	330182	02.2748	330246	01.1757
320035	01.0732	330033	01.1243	330106	01.5433	330183	01.4318	330247	00.6020
320037	01.2479	330034	01.0723	330107	01.2394	330184	01.2495	330249	01.1964
320038	01.2570	330036	01.2036	330108	01.2452	330185	01.1809	330250	01.2499
320046	01.0924	330037	01.0767	330110	01.0962	330186	00.9961	330252	00.9324
320048	01.2282	330038	01.1750	330111	01.1248	330188	01.1807	330254	00.9844
320056	00.9453	330039	00.8940	330114	00.9982	330189	00.8684	330258	01.3202
320057	01.0938	330041	01.3626	330115	01.2553	330191	01.2528	330259	01.3134
320058	00.8775	330043	01.2780	330116	01.0004	330193	01.3674	330261	01.2055
320059	01.0857	330044	01.2124	330118	01.5905	330194	01.7304	330263	01.0704
320060	00.9163	330045	01.2999	330119	01.5732	330195	01.6563	330264	01.2158
320061	01.2288	330046	01.5848	330121	01.0137	330196	01.3772	330265	01.2840
320062	00.8894	330047	01.2787	330122	01.2779	330197	01.0166	330267	01.2482
320063	01.2761	330048	01.2433	330125	01.7608	330198	01.3351	330268	01.1270
320065	01.1642	330049	01.3131	330126	01.2178	330199	01.2794	330270	01.8912

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330273	01.1818	330394	01.3836	340049	00.5900	340121	00.9534
330275	01.2036	330395	01.3399	340050	01.2019	340122	01.0402
330276	01.1937	330396	01.2279	340051	01.1942	340123	01.0561
330277	01.1679	330397	01.4256	340052	00.9710	340124	01.0969
330279	01.2534	330398	01.3058	340053	01.5724	340125	01.4446
330281	00.5845	330399	01.3674	340054	00.9793	340126	01.2844
330285	01.6000	330698	00.5377	340055	01.1581	340127	01.2259
330286	01.3285	330699	00.5933	340060	01.1859	340129	01.1190
330288	01.0172	340001	01.2439	340061	01.6056	340130	01.3969
330290	01.6601	340002	01.7820	340062	01.0220	340131	01.3435
330293	01.1152	340003	01.1432	340064	01.1011	340132	01.3657
330304	01.1618	340004	01.3930	340065	01.2382	340133	01.2081
330308	01.3793	340005	01.2186	340067	01.1095	340135	01.0705
330307	01.1383	340006	01.1747	340068	01.2600	340136	00.8650
330308	01.2434	340007	01.1159	340069	01.7413	340137	01.2023
330309	01.2846	340008	01.2221	340070	01.2915	340138	01.1161
330314	01.2954	340009	01.2706	340071	01.0893	340141	01.5263
330315	01.1883	340010	01.3135	340072	01.0470	340142	01.1674
330316	01.2443	340011	01.0800	340073	01.3473	340143	01.3674
330327	00.9478	340012	01.0754	340075	01.1885	340144	01.2598
330331	01.1957	340013	01.1941	340076	01.0245	340145	01.1897
330332	01.2665	340014	01.6266	340080	01.0938	340146	01.0141
330333	01.3099	340015	01.2265	340084	01.0217	340147	01.2841
330336	01.2740	340016	01.2028	340085	01.2478	340148	01.3166
330338	01.1616	340017	01.2021	340087	01.0869	340151	01.1652
330339	00.8648	340018	01.2130	340088	01.0748	340153	01.9099
330340	01.1313	340019	01.0666	340089	01.0036	340154	00.9800
330350	01.8946	340020	01.2499	340090	01.1399	340155	01.4954
330351	01.0933	340021	01.2157	340091	01.6623	340156	00.8579
330353	01.2145	340022	01.1448	340093	01.0485	340158	01.0443
330354	01.1615	340023	01.3133	340094	01.3397	340159	01.2070
330357	01.3723	340024	01.2259	340096	01.2118	340160	01.0404
330359	00.9412	340025	01.0964	340097	01.0040	340162	01.2682
330362	00.6536	340027	01.1215	340098	01.6166	340164	01.3371
330363	00.6845	340028	01.3883	340099	01.1462	340166	01.3205
330366	00.7261	340030	01.7642	340100	01.0987	340167	00.5762
330367	00.5681	340031	01.0764	340101	01.0661	340168	00.5394
330368	00.6233	340032	01.2951	340104	01.0037	340898	00.6959
330369	00.6711	340034	01.2774	340105	01.3337	340899	00.5704
330371	00.6549	340035	01.0880	340106	01.1051	350001	01.1012
330372	01.2391	340036	01.0849	340107	01.2960	350002	01.6350
330373	00.6795	340037	01.2492	340109	01.2881	350003	01.1388
330381	01.3061	340038	01.2031	340111	01.1685	350004	01.8746
330383	01.3768	340039	01.2352	340112	01.0075	350005	01.1909
330385	01.2000	340040	01.7179	340113	01.9528	350006	01.3931
330386	01.2119	340041	01.2312	340114	01.3849	350007	01.0256
330387	00.8627	340042	01.1518	340115	01.4475	350008	01.0437
330389	01.8157	340044	01.0104	340116	01.7306	350009	01.1634
330390	01.2245	340045	00.9701	340119	01.2109	350010	01.0859
330393	01.6510	340047	01.7865	340120	01.0633	350011	01.7361

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360008	01.1885	360064	01.4600	360120	00.7106	360179	01.2535	370020	01.2583
360009	01.3042	360065	01.2015	360121	01.1847	360180	02.1065	370021	00.9723
360010	01.1622	360066	01.2308	360122	01.2237	360181	00.7100	370022	01.3410
360011	01.2673	360067	01.1829	360123	01.1505	360185	01.1692	370023	01.3165
360012	01.2772	360068	01.4427	360124	01.2238	360186	01.1560	370025	01.3100
360013	01.0931	360069	01.0316	360125	01.0834	360187	01.3206	370026	01.3143
360014	01.1689	360070	01.4018	360126	01.2596	360188	00.9687	370028	01.6147
360015	01.4481	360071	01.2758	360127	01.0204	360189	01.0651	370029	01.2188
360016	01.4685	360072	01.1559	360128	01.0601	360192	01.2783	370030	01.2113
360017	01.7324	360074	01.3153	360129	01.0463	360193	01.2608	370032	01.3442
360018	01.3731	360075	01.4178	360130	01.1047	360194	01.0646	370033	01.2104
360019	01.1745	360076	01.2600	360131	01.2733	360195	01.1869	370034	01.1218
360020	01.2387	360077	01.3972	360132	01.1794	360197	01.1575	370035	01.5126
360021	01.2084	360078	01.2704	360133	01.3232	360200	01.2071	370036	01.1042
360024	01.2724	360079	01.6191	360134	01.5318	360203	01.1218	370037	01.5306
360025	01.2127	360080	01.2267	360135	01.1194	360204	01.1640	370038	01.0635
360026	01.1237	360081	01.3315	360136	01.0698	360210	01.1851	370039	01.2286
360027	01.4963	360082	01.3182	360137	01.5094	360211	01.1710	370040	01.0324
360028	01.3266	360083	01.2132	360139	01.1154	360212	01.4200	370041	01.0246
360029	01.1008	360084	01.4106	360140	01.0630	360213	01.0973	370042	00.8843
360030	01.1579	360085	01.6739	360141	01.4123	360218	01.3145	370043	00.9562
360031	01.2545	360086	01.3417	360142	00.9861	360230	01.2830	370045	01.0659
360032	01.1178	360087	01.3150	360143	01.2290	360231	01.1230	370046	01.0201
360034	01.0803	360088	01.1521	360144	01.2917	360232	01.1335	370047	01.2533
360035	01.4548	360089	01.1109	360145	01.4940	360234	01.2280	370048	01.2083
360036	01.1750	360090	01.1711	360147	01.2193	360236	01.2063	370049	01.2957
360037	01.8293	360091	01.3045	360148	01.1836	360238	00.8516	370050	00.8128
360038	01.4265	360092	01.1612	360149	01.0858	360239	01.2051	370051	01.0003
360039	01.2393	360093	01.1582	360150	01.2099	360240	00.5398	370054	01.2476
360040	01.2684	360094	01.2206	360151	01.2817	360241	00.6470	370056	01.4618
360041	01.2353	360095	01.2945	360152	01.4955	360242	01.5841	370057	01.0880
360042	01.0930	360096	01.1047	360153	01.1568	360243	00.9016	370059	01.2278
360044	01.0944	360098	01.3047	360154	01.0441	360898	00.7055	370060	01.0457
360045	01.5035	360099	01.0450	360155	01.2076	360899	00.6006	370063	01.1852
360046	01.1259	360100	01.2811	360156	01.1317	370001	01.6630	370065	01.1241
360047	01.1087	360101	01.6026	360158	01.1440	370002	01.1831	370066	00.9042
360048	01.7146	360102	01.2225	360159	01.1440	370004	01.1904	370069	01.0116
360049	01.2561	360103	01.3406	360161	01.2195	370005	00.9163	370071	01.0079
360050	01.2480	360104	00.8889	360162	01.2199	370006	01.2095	370072	00.9698
360051	01.4791	360106	01.1637	360163	01.6523	370007	01.1117	370075	01.1117
360052	01.5950	360107	01.2072	360164	00.9753	370008	01.2182	370077	01.2633
360054	01.2983	360108	01.0218	360165	01.0777	370011	00.9381	370078	01.5373
360055	01.1899	360109	01.0370	360166	01.0321	370012	00.9169	370079	00.9247
360056	01.2907	360112	01.6095	360169	01.0140	370013	01.4016	370080	00.9494
360057	00.9616	360113	01.2408	360170	01.1557	370014	01.1517	370082	00.9971
360058	01.1008	360114	01.0511	360172	01.3402	370015	01.1269	370083	00.9946
360059	01.4813	360115	01.2479	360174	01.1523	370016	01.2491	370084	00.8590
360061	00.8603	360116	01.0275	360175	01.1492	370017	00.9861	370085	00.8928
360062	01.6108	360118	01.2524	360176	01.1366	370018	01.1800	370086	01.0952
360063	01.0531	360119	01.2161	360177	01.2603	370019	01.1325	370089	01.2511
				360178	01.2593				

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370091	01.5313	370179	01.0750	380056	01.0380	390023	01.2283
370092	01.0351	370180	01.0228	380059	00.9145	390024	00.7847
370093	01.6174	370183	01.0842	380060	01.3258	390025	00.8124
370094	01.2787	370185	00.6561	380061	01.6086	390026	01.2380
370095	00.9083	370186	00.9634	380062	00.9536	390027	01.7205
370097	01.2421	370189	00.9860	380063	01.2683	390028	01.6786
370099	01.1489	370190	01.3183	380064	01.3214	390029	01.6470
370100	01.0450	370898	00.7011	380065	01.0798	390030	01.1475
370103	00.9072	370899	00.5933	380066	01.0718	390031	01.1584
370105	01.8882	380001	01.3203	380068	01.0718	390032	01.2139
370106	01.3370	380002	01.2313	380069	01.1687	390035	01.2510
370108	01.0358	380003	01.1420	380070	01.0683	390036	01.2135
370110	00.9971	380004	01.8249	380071	01.2575	390037	01.2069
370112	00.9205	380005	01.2024	380072	00.9369	390039	01.0661
370113	01.0953	380006	01.1757	380075	01.3712	390040	00.9802
370114	01.5430	380007	01.7822	380078	01.1830	390041	01.2212
370117	01.3063	380008	01.0571	380081	01.0498	390042	01.2589
370121	01.1788	380009	01.6433	380082	01.2904	390043	01.0783
370122	00.9339	380010	01.1516	380083	01.1659	390044	01.5304
370123	01.1579	380011	01.1471	380084	01.2609	390045	01.2991
370125	00.9808	380013	01.2419	380087	00.9779	390046	01.4233
370126	01.0998	380014	01.3127	380088	00.9280	390047	01.4582
370131	00.9952	380017	01.7214	380089	01.3307	390048	01.1050
370133	01.1936	380018	01.8707	380090	01.3307	390049	01.5231
370138	01.1842	380019	01.2649	380091	01.1711	390050	01.8804
370139	01.0073	380020	01.3445	380094	01.1491	390051	02.0915
370140	01.0652	380021	01.2315	380096	01.1107	390052	01.1415
370141	01.4378	380022	01.2338	380098	00.6959	390054	01.1127
370146	01.0242	380023	01.2872	380099	00.5933	390055	01.8890
370148	01.2687	380024	01.2863	380001	01.2248	390056	01.0962
370149	01.2109	380025	01.2421	390002	01.1848	390057	01.2574
370153	01.0973	380026	01.4084	390003	01.1522	390058	01.3240
370154	01.0248	380027	01.2104	390004	01.2474	390059	01.3276
370156	01.0210	380029	01.1555	390005	01.0906	390060	01.1557
370157	00.9195	380030	00.8953	390006	01.6859	390061	01.2393
370158	01.0514	380031	01.0175	390007	01.1727	390062	01.1877
370159	01.1521	380033	01.6755	390008	01.1245	390063	01.6215
370161	01.1959	380035	01.1882	390009	01.4983	390064	01.4194
370163	00.8649	380036	01.0905	390010	01.1734	390065	01.2442
370165	01.1643	380037	01.2117	390011	01.2003	390066	01.2878
370168	01.1656	380038	01.2444	390012	01.1959	390067	01.5103
370169	00.9955	380039	01.3112	390013	01.1550	390068	01.2594
370170	00.8238	380040	01.3427	390014	00.8159	390069	01.2592
370171	00.9463	380042	01.1124	390015	01.1104	390070	01.1882
370172	00.8966	380047	01.5541	390016	01.1716	390071	01.1218
370173	01.0663	380048	00.9951	390017	01.1495	390072	00.9335
370174	00.9662	380050	01.3293	390018	01.2180	390073	01.4717
370176	01.2706	380051	01.4251	390019	01.1113	390074	01.2243
370177	00.9393	380052	01.1735	390021	01.0658	390075	01.3036
370178	01.0007	380055	01.1787	390022	01.2705	390076	01.2570

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390139	01.4427	390197	01.2864	390277	01.4534	400111	01.2195	420036	01.2537
390142	01.7099	390198	01.2504	390278	00.8975	400112	01.2237	420037	01.2720
390143	03.1916	390199	01.2182	390279	00.6478	400113	01.2075	420038	01.2051
390145	01.2120	390200	01.0823	390280	00.5756	400114	01.0776	420039	01.1188
390146	01.1901	390201	01.3181	400001	01.1869	400115	01.0326	420040	01.2934
390147	01.1880	390203	01.2909	400002	01.2608	400117	01.1714	420042	01.0812
390148	01.1487	390204	01.2726	400003	01.1319	400118	01.1614	420043	01.1473
390149	01.2551	390205	01.2345	400004	01.1172	400120	01.3128	420044	01.1484
390150	01.1998	390206	01.2600	400005	01.1165	400121	01.0225	420048	01.1354
390151	01.2693	390209	00.9546	400006	01.1717	400898	00.7124	420049	01.0893
390152	01.0243	390211	01.1389	400007	01.0901	400899	00.5933	420051	01.5386
390153	01.2058	390213	01.0185	400008	01.1139	410001	01.2640	420053	01.0857
390154	01.1150	390215	01.1789	400009	00.9820	410002	01.2483	420054	01.1379
390155	01.2832	390217	01.1413	400010	00.9631	410004	01.4267	420055	01.0351
390156	01.3735	390219	01.1923	400011	01.1131	410005	01.2981	420056	01.0152
390157	01.1812	390220	01.1139	400012	01.0397	410006	01.1874	420057	01.0846
390158	01.2492	390222	01.2000	400013	01.0272	410007	01.5205	420059	01.0531
390159	01.3079	390223	01.5759	400014	01.3318	410008	01.1990	420061	01.2593
390160	01.1721	390224	00.9580	400015	01.0801	410009	01.3382	420062	01.2822
390161	01.0728	390225	01.2692	400016	01.2660	410010	01.0374	420064	01.0772
390162	01.2402	390226	01.6126	400017	01.1062	410011	01.1929	420065	01.3053
390163	01.2013	390228	01.1929	400018	01.2698	410012	01.5862	420066	01.0015
390164	01.8775	390229	01.4457	400019	01.3510	410013	01.1477	420067	01.1124
390165	01.0801	390231	01.3036	400021	01.3106	410898	00.7124	420068	01.1785
390166	01.1110	390232	01.0866	400022	01.2852	410899	00.5933	420069	01.0072
390167	01.2332	390233	01.2834	400024	01.0343	420002	01.3260	420070	01.2626
390168	01.1968	390235	01.8436	400026	00.9306	420004	01.3694	420071	01.3694
390169	01.2263	390236	01.2111	400027	01.0976	420005	01.1085	420072	01.0073
390170	01.6284	390237	01.4882	400028	01.0450	420006	01.5297	420073	01.2811
390171	01.0849	390238	00.9991	400029	01.0198	420007	01.4123	420074	00.9710
390172	01.1793	390242	01.2145	400031	01.0733	420009	01.2309	420075	01.0716
390173	01.1246	390244	00.8734	400032	01.1247	420010	01.0818	420076	01.2637
390174	01.5844	390245	01.3513	400037	00.5692	420011	01.0829	420078	01.5714
390176	01.2046	390246	01.2118	400038	00.9750	420014	01.1158	420079	01.5497
390178	01.3257	390247	01.1039	400044	01.2547	420015	01.2538	420080	01.1505
390179	01.2349	390249	00.9705	400048	01.1327	420016	01.2156	420081	00.7982
390180	01.3894	390252	00.9369	400061	01.7728	420018	01.6260	420082	01.3708
390181	01.0718	390256	01.6519	400079	01.1418	420019	01.1687	420083	01.1952
390183	01.1446	390258	01.2930	400087	01.2463	420020	01.1766	420084	00.8372
390184	01.1044	390260	01.2363	400088	00.7437	420022	00.9970	420085	01.2551
390185	01.1571	390261	01.8268	400089	01.0897	420023	01.2479	420086	01.3756
390186	01.0995	390262	01.6813	400094	00.9192	420026	01.8115	420087	01.5254
390187	01.0994	390263	01.4368	400098	01.2320	420027	01.3416	420088	01.1805
390189	01.1126	390265	01.2574	400102	01.0991	420028	01.0602	420089	01.2609
390191	01.0654	390266	01.1242	400103	01.4111	420029	01.8435	420090	00.5933
390192	01.0701	390267	01.2187	400104	01.2781	420030	01.1604	420099	00.5933
390193	01.1907	390268	01.2201	400105	01.2795	420031	00.9787	430004	01.0610
390194	01.0999	390270	01.3042	400106	01.1440	420032	00.8739	430005	01.3185
390195	01.5428	390272	00.6193	400109	01.5059	420033	01.1658	430007	01.1426
390196	01.2912	390275	00.5439	400110	01.1676	420035	00.8266	430008	01.2152

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
430009	01.0311	430084	01.0086	440059	01.1388	440146	01.3387
430010	01.0947	430085	00.9279	440060	01.2150	440147	00.7335
430011	01.3501	430086	00.8651	440061	01.1043	440148	01.1316
430012	01.3030	430087	01.0579	440062	01.0984	440149	01.1647
430013	01.2439	430088	00.9259	440063	01.0984	440150	01.2898
430014	01.1898	440001	00.9701	440064	01.1393	440151	01.1705
430015	01.0331	440002	01.5635	440065	01.1641	440152	01.5789
430016	01.7030	440003	01.1093	440066	01.1625	440153	00.9846
430017	01.0879	440004	01.3877	440067	01.0897	440154	00.7352
430018	00.9467	440005	01.0247	440068	00.9311	440155	01.4045
430019	00.9431	440006	00.9625	440069	01.3252	440156	01.0030
430020	00.9419	440007	01.0302	440070	01.3619	440157	01.2169
430021	01.0061	440008	00.9354	440071	01.2878	440158	01.0547
430022	01.0061	440009	01.2239	440072	00.8640	440159	01.5777
430023	01.0109	440010	01.3394	440073	01.0115	440160	01.0043
430024	00.8677	440011	00.8841	440074	00.8339	440161	01.2809
430025	01.6594	440012	01.4882	440075	01.1405	440162	01.0334
430026	01.0992	440013	00.9545	440076	01.8142	440163	01.4968
430027	00.9978	440014	01.2863	440077	01.2404	440164	01.4719
430028	00.9946	440015	01.4827	440078	01.0804	440165	01.4609
430029	00.9962	440016	01.2963	440079	01.0114	440166	01.1670
430030	01.0563	440017	01.4679	440080	01.3862	440167	01.6219
430031	00.9962	440018	01.2168	440081	01.0961	440168	00.9493
430032	01.0365	440019	01.0828	440082	01.3862	440169	01.6210
430033	00.9672	440020	01.1533	440083	01.0858	440170	01.4135
430034	01.0455	440021	01.2274	440084	01.0961	440171	01.5010
430035	01.0939	440022	01.2676	440085	01.2834	440172	01.3774
430036	00.9229	440023	01.2274	440086	01.4361	440173	01.0038
430037	01.0916	440024	01.0530	440087	01.3158	440174	01.2953
430038	01.1354	440025	01.0537	440088	01.0700	440175	01.6324
430039	00.9242	440026	01.0885	440089	01.2814	440176	01.0335
430040	00.9914	440027	01.0885	440090	01.1522	440177	01.1861
430041	00.9401	440028	01.1732	440091	01.4553	440178	01.6181
430042	00.8737	440029	00.9220	440092	01.0594	440179	01.5148
430043	00.9685	440030	01.5792	440093	01.4373	440180	01.2827
430044	00.9537	440031	00.8988	440094	00.9216	440181	01.3405
430045	00.8552	440032	00.8852	440095	01.1124	440182	00.9390
430046	00.8552	440033	00.9236	440096	01.1110	440183	00.9063
430047	01.0464	440034	00.9236	440097	01.0456	440184	01.4570
430048	01.0464	440035	01.5935	440098	01.4550	440185	01.1392
430049	00.9444	440036	01.6165	440099	01.4550	440186	01.5065
430050	01.0543	440037	01.1555	440100	01.3845	440187	01.6864
430051	01.1100	440038	00.9219	440101	01.2579	440188	01.1236
430052	01.0089	440039	01.1555	440102	01.0527	440189	01.1840
430053	01.4189	440040	01.1555	440103	00.9151	440190	01.1736
430054	01.0408	440041	01.1704	440104	01.0537	440191	01.1915
430055	00.8204	440042	00.9825	440105	01.0324	440192	01.2381
430056	01.0026	440043	00.9854	440106	01.1294	440193	00.9754
430057	00.8949	440044	00.9617	440107	00.9332	440194	00.9893
430058	00.8473	440045	01.1467	440108	00.9332	440195	01.4452

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450080	01.1702	450153	01.5808	450234	00.9339	450351	01.2629	450484	01.5176
450081	01.1807	450154	01.1220	450235	01.0289	450352	01.2194	450486	00.9476
450082	00.9919	450155	01.0584	450236	01.1313	450353	01.1300	450488	01.2052
450083	01.5521	450157	01.0128	450237	01.5059	450355	01.1050	450489	01.0417
450085	00.9963	450160	01.0277	450239	01.1984	450358	01.9688	450497	01.1283
450087	01.3391	450162	01.3390	450241	00.9570	450362	00.9602	450498	01.0559
450090	01.1520	450163	01.1107	450243	00.9256	450365	00.9674	450508	01.4144
450092	01.2884	450164	00.9291	450246	00.9993	450366	01.6512	450514	01.1391
450094	01.3869	450165	00.9342	450249	00.9333	450369	01.1976	450517	00.9456
450096	01.4927	450166	00.8710	450253	01.0894	450370	01.1805	450518	01.3298
450097	01.4102	450169	00.8654	450258	01.1207	450371	01.1090	450523	01.4783
450098	01.1212	450170	01.1030	450259	01.2272	450372	01.3069	450530	01.3074
450099	01.2182	450175	01.1695	450264	00.8619	450373	01.1578	450534	00.9581
450101	01.3864	450176	01.2791	450268	01.2150	450374	00.8738	450535	01.2197
450102	01.6956	450177	01.1028	450269	00.9470	450376	01.4582	450537	01.3805
450104	01.2475	450178	01.0727	450270	01.1469	450378	01.2817	450538	01.2929
450107	01.4170	450179	01.0314	450271	01.1899	450379	01.5651	450539	01.2635
450108	00.9755	450181	01.0091	450272	01.3338	450381	00.8885	450544	01.2441
450109	00.9858	450183	00.9973	450276	00.9935	450388	01.6342	450545	01.1621
450110	01.2221	450184	01.4694	450278	00.9019	450389	01.2288	450546	01.3549
450111	01.1780	450185	01.0479	450280	01.3141	450393	01.2912	450547	00.9694
450112	01.2148	450187	01.1856	450283	01.1470	450395	01.0765	450550	01.0390
450113	01.2870	450188	00.9714	450286	01.0916	450399	01.0324	450551	01.0309
450115	01.0676	450190	01.2586	450288	01.1421	450400	01.0697	450557	01.0522
450118	01.4149	450191	01.1034	450289	01.3842	450403	01.2084	450558	01.7843
450119	01.2402	450192	01.0860	450292	01.2537	450410	01.0562	450559	00.8868
450121	01.3731	450193	02.1589	450293	00.9902	450411	01.0614	450561	01.5104
450123	01.0640	450194	01.1285	450296	01.2171	450417	01.0327	450563	01.2053
450124	01.4598	450195	01.4252	450297	01.0690	450418	01.3688	450565	01.2918
450126	01.3117	450196	01.2384	450299	01.3459	450419	01.2443	450570	01.0129
450127	00.9705	450197	01.2032	450303	00.9486	450422	00.7583	450571	01.4388
450128	01.1501	450200	01.2931	450306	01.0436	450423	01.3455	450573	01.0348
450130	01.4654	450201	00.9801	450307	00.9979	450424	01.2620	450574	01.0248
450131	01.2387	450203	01.1710	450309	01.0402	450428	00.9315	450575	00.9941
450132	01.4478	450207	01.0862	450315	01.2236	450431	01.5019	450578	00.8649
450133	01.3367	450208	02.6823	450320	01.3068	450438	01.0544	450580	01.1793
450135	01.5678	450209	01.3417	450321	00.8834	450446	00.9118	450583	01.0090
450137	01.3454	450210	01.2006	450322	00.9486	450447	01.2783	450584	01.1749
450140	00.9018	450211	01.2561	450324	01.5258	450450	01.0858	450586	01.1145
450142	01.2795	450213	01.4343	450325	01.1917	450451	01.0166	450587	01.2594
450143	01.0184	450214	01.3070	450327	00.9892	450457	01.8706	450591	01.2424
450144	01.1376	450217	00.8680	450330	01.0898	450460	00.9721	450596	01.2329
450145	00.9723	450218	00.9966	450334	01.0666	450462	01.5906	450597	01.0384
450146	01.0127	450219	01.1242	450337	01.1856	450464	00.9138	450603	00.8644
450147	01.3529	450221	00.9881	450340	01.3507	450465	01.1064	450604	01.2342
450148	01.3120	450222	01.6916	450341	00.9360	450467	01.0551	450605	01.2250
450149	01.4242	450224	01.1342	450346	01.3101	450469	01.2731	450607	00.8998
450150	01.0191	450229	01.3599	450347	01.2250	450473	01.0851	450609	00.8576
450151	01.0829	450231	01.5954	450348	00.9782	450475	01.1437	450610	01.3851
450152	01.4143	450233	01.0909	450349	01.1459	450476	01.0202	450614	01.0259

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450615	00.9536	450691	01.1613	450766	01.6145	470001	01.1553	490043	01.1753
450617	01.3711	450694	01.2182	450768	01.0854	470003	01.9216	490044	01.2720
450620	01.0812	450696	01.0786	450769	00.9330	470004	01.1731	490045	01.1529
450623	01.1476	450697	01.4611	450770	00.9871	470005	01.1976	490046	01.3425
450626	00.9847	450698	00.9556	450771	01.4283	470006	01.2796	490047	01.1639
450628	00.9852	450700	00.9224	450773	01.1471	470008	01.2179	490048	01.3228
450630	01.6381	450702	01.2762	450775	01.1682	470010	01.0269	490050	01.3131
450631	01.6317	450703	01.2745	450898	00.5372	470011	01.1543	490052	01.4080
450632	00.9899	450704	01.2882	450899	00.5933	470012	01.2574	490053	01.2126
450633	01.5660	450705	00.8070	480001	01.6016	470013	01.1251	490054	01.0640
450634	01.3371	450706	01.2435	480003	01.4090	470015	01.2147	490057	01.3413
450637	01.3089	450709	01.1897	480004	01.7104	470018	01.1755	490059	01.4063
450638	01.4822	450711	01.2454	480005	01.2454	470020	01.0039	490060	01.0832
450639	01.5131	450712	00.7254	480006	01.3409	470023	01.2332	490063	01.5838
450641	00.8878	450713	01.2507	480007	01.3771	470024	01.1079	490066	01.1103
450643	01.1682	450715	01.3715	480008	01.3177	490001	01.1387	490067	01.2667
450644	01.6063	450716	01.2262	480009	01.7617	490002	01.0308	490069	01.3553
450646	01.4764	450717	01.2323	480010	01.9808	490003	00.6383	490071	01.2842
450647	01.9626	450718	01.1212	480011	01.3147	490004	01.2117	490073	01.2107
450648	01.1072	450723	01.2479	480013	01.4278	490005	01.4018	490074	01.2452
450649	01.0714	450724	01.1884	480014	01.0575	490006	01.1329	490075	01.2427
450651	01.8222	450725	00.9412	480015	01.2503	490007	01.9211	490077	01.1728
450652	00.9569	450726	00.8623	480016	00.9768	490008	01.1192	490079	01.2327
450653	01.2340	450727	00.9602	480017	01.2157	490009	01.6423	490083	00.7777
450654	00.9878	450728	00.8694	480018	00.9469	490010	01.1743	490084	01.1377
450656	01.2664	450729	00.9587	480019	00.9871	490011	01.2750	490085	01.2287
450658	00.9579	450730	01.3964	480020	00.9421	490012	01.0049	490088	01.1241
450659	01.4426	450732	01.1773	480021	01.2899	490013	01.1182	490089	01.0397
450660	01.6533	450733	01.3126	480022	00.9610	490014	01.5665	490090	01.1350
450661	01.2200	450734	01.2399	480023	01.1392	490015	01.4621	490091	01.1648
450662	01.4437	450735	00.8450	480024	01.0085	490017	01.2820	490092	01.1219
450665	00.9783	450737	00.8791	480025	00.8483	490018	01.0968	490093	01.2530
450666	01.2154	450742	01.3280	480026	00.9616	490019	01.1421	490094	01.0831
450668	01.5214	450743	01.4463	480027	00.9446	490020	01.0727	490095	01.2819
450669	01.3213	450745	00.8077	480029	00.9550	490021	01.3966	490097	01.1400
450670	01.2267	450746	00.8982	480030	01.1082	490022	01.2210	490098	01.2638
450672	01.5935	450747	01.3199	480032	00.9744	490023	01.1902	490099	00.9339
450673	01.0142	450749	01.0312	480033	00.9922	490024	01.6454	490100	01.2995
450674	00.8497	450750	00.9812	480035	00.9074	490027	01.0346	490101	01.1062
450675	01.3358	450751	01.3228	480036	00.9919	490028	01.2915	490104	00.8727
450677	01.3343	450753	00.8613	480037	00.9503	490030	01.3058	490105	00.7232
450678	01.4926	450754	00.8778	480039	00.9546	490031	01.0659	490106	00.8091
450681	01.5291	450755	01.0099	480041	01.2425	490032	01.6518	490107	01.2613
450682	01.2877	450757	00.9658	480042	01.3774	490033	01.2290	490108	00.8697
450683	01.2976	450758	01.4997	480043	01.2879	490035	01.3112	490109	00.8224
450684	01.2924	450759	01.1293	480044	01.1249	490037	01.1306	490110	01.2084
450685	01.2284	450760	01.3408	480046	00.9837	490038	01.2374	490111	01.1711
450686	01.3757	450761	00.9399	480047	01.6139	490040	01.3881	490112	01.5160
450688	01.3312	450763	01.0429	480048	00.7066	490041	01.1724	490113	01.2372
450690	01.3172	450765	01.0829	480099	00.5933	490042	01.2836	490114	01.0184

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
490115	01.1527	500048	00.9335	500123	01.0131	510050	01.2320	520031	01.1652
490116	01.1860	500049	01.2302	500124	01.3235	510053	01.0007	520032	01.1489
490117	01.0709	500050	01.2740	500125	00.9519	510055	01.1703	520033	01.2565
490118	01.7037	500051	01.6318	500127	01.0546	510058	01.2083	520034	01.1890
490119	01.3368	500052	01.2202	500129	01.5826	510059	01.3569	520035	01.2525
490120	01.3135	500053	01.2395	500132	00.8229	510060	01.1631	520037	01.8022
490121	01.2100	500054	01.8326	500134	00.7324	510061	01.0428	520038	01.2987
490122	01.1422	500055	01.0012	500135	01.1248	510062	01.1423	520039	01.0161
490123	01.2071	500057	01.2807	500137	00.8154	510063	01.0510	520040	01.4177
490126	01.1959	500058	01.3179	500138	01.3357	510065	00.9971	520041	01.1157
490127	01.0639	500059	01.1485	500139	01.3357	510066	01.1441	520042	01.0195
490129	01.1401	500060	01.1850	500140	00.9810	510067	01.2705	520044	01.3324
490130	01.2419	500061	01.1698	500141	01.2473	510068	01.1017	520045	01.6515
490131	00.9471	500062	00.9538	500143	00.5857	510070	01.1866	520047	00.9726
490898	00.6901	500064	01.5581	500898	00.6949	510071	01.2579	520048	01.3234
500001	01.3064	500065	01.2768	500899	00.6006	510072	01.0285	520049	01.8058
500002	01.4458	500068	01.1688	510001	01.6679	510076	00.9875	520051	02.0395
500003	01.2859	500069	00.9942	510002	01.2809	510077	01.1330	520053	01.0651
500005	01.7205	500071	01.4231	510004	00.9722	510080	00.9924	520054	01.1973
500007	01.3026	500072	01.1843	510005	00.9811	510081	01.0027	520056	01.2998
500008	01.9064	500073	00.9397	510006	01.3758	510082	00.9458	520057	01.1426
500011	01.2214	500074	01.1160	510007	01.1685	510084	00.9458	520058	01.1022
500012	01.4978	500075	01.1804	510008	01.1685	510085	01.1980	520059	01.2665
500014	01.6616	500077	01.2325	510009	01.0270	510086	01.0419	520060	01.2399
500015	01.2854	500078	01.2968	510012	01.0406	510087	00.7818	520062	01.1771
500016	01.3859	500079	01.2518	510013	01.1448	520002	01.2749	520063	01.1928
500019	01.2500	500080	00.9282	510015	00.9202	520003	01.1458	520064	01.5249
500021	01.3900	500084	01.0119	510016	01.0086	520004	01.2492	520066	01.2379
500023	01.1981	500085	01.0574	510018	01.1258	520006	01.0211	520068	01.0636
500024	01.3352	500086	01.3083	510020	01.0994	520007	01.0786	520069	01.1985
500025	01.9341	500088	01.0363	510022	01.6317	520008	01.2066	520070	01.3206
500026	01.2809	500089	01.0355	510023	01.0319	520009	01.4828	520071	01.1777
500027	01.5774	500090	00.9145	510024	01.3182	520010	01.1006	520074	01.1111
500028	00.9916	500092	01.1105	510025	00.9089	520011	01.0878	520075	01.3986
500029	00.9016	500093	01.1741	510026	00.9774	520012	00.9378	520076	01.1655
500030	01.3451	500094	00.9211	510027	01.0039	520013	01.3000	520077	01.0303
500031	01.2379	500096	01.0396	510028	01.0582	520014	01.1698	520078	01.3126
500033	01.1721	500097	01.1722	510029	01.2375	520015	01.1637	520081	01.2238
500034	00.9292	500098	00.8660	510030	01.1182	520016	00.9800	520082	01.2960
500035	01.3857	500101	00.9255	510031	01.2725	520017	01.1687	520083	01.5012
500036	01.2761	500102	00.9850	510033	01.2116	520018	00.9887	520084	01.0843
500037	01.1628	500104	01.2724	510035	01.0518	520019	01.2358	520087	01.4903
500039	01.3067	500106	00.9994	510036	01.0958	520021	01.1859	520088	01.2162
500041	01.2100	500107	01.1449	510038	01.0036	520024	00.9859	520089	01.4093
500042	01.3030	500108	01.6490	510039	01.2756	520025	01.1238	520090	01.1472
500043	01.1757	500110	01.2213	510040	00.9728	520026	01.0338	520091	01.2351
500044	01.9124	500118	01.1950	510043	01.0028	520027	01.1475	520092	01.1657
500045	01.1611	500119	01.2518	510046	01.2549	520028	01.3674	520094	01.1705
		500122	01.2276	510047	01.1247	520029	00.9306	520095	01.3066
		510048	01.1451	510048	01.1451	520030	01.5286	520096	01.4422

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 23 OF 23

PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
520097 01.2957	520173 01.0630		
520098 01.6973	520174 01.4653		
520100 01.2329	520176 00.8295		
520101 01.1582	520177 01.5402		
520102 01.1985	520178 01.1607		
520103 01.3448	520180 00.5761		
520104 00.9950	520898 00.7124		
520107 01.2347	520899 00.6006		
520109 01.0764	530001 01.2405		
520110 00.9832	530002 01.1456		
520111 01.0896	530003 00.9566		
520112 01.1216	530004 00.9964		
520113 01.2121	530005 01.0804		
520114 01.0560	530006 01.0912		
520115 01.2905	530007 01.0418		
520116 01.1972	530008 01.1467		
520117 01.0769	530009 00.9850		
520118 00.9365	530010 01.2582		
520120 01.0775	530011 01.1237		
520121 00.9657	530012 01.6087		
520122 01.0398	530014 01.1254		
520123 01.0393	530015 01.1318		
520124 01.1554	530016 01.1459		
520130 01.0636	530017 00.9856		
520131 01.0723	530018 01.0635		
520132 01.1596	530019 00.9848		
520134 01.1496	530022 01.1262		
520135 01.0653	530023 00.9055		
520136 01.4682	530024 00.9604		
520138 01.8465	530025 01.2472		
520139 01.1979	530026 01.0539		
520140 01.4135	530027 00.8637		
520141 01.0937	530029 00.8958		
520142 00.9855	530031 00.9951		
520144 01.0099	530032 01.2402		
520145 01.0208	530898 00.7113		
520146 01.1638			
520148 01.0991			
520149 01.0493			
520151 01.0604			
520152 01.1405			
520153 01.0127			
520154 01.1128			
520156 01.0859			
520157 01.0042			
520159 00.9120			
520160 01.7563			
520161 01.0644			
520170 01.3000			
520171 00.9913			

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

BILLING CODE 4120-03-C

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Abilene, TX.....	0.9425	0.9603
Taylor, TX.....		
Aguadilla, PR.....	0.4566	0.5846
Aguada, PR.....		
Aguadilla, PR.....		
Isabella, PR.....		
Moca, PR.....		
Akron, OH.....	0.8917	0.9245
Portage, OH.....		
Summit, OH.....		
Albany, GA.....	0.8046	0.8617
Dougherty, GA.....		
Lee, GA.....		
Albany-Schenectady-Troy, NY.....	0.8953	0.9271
Albany, NY.....		
Greene, NY.....		
Montgomery, NY.....		
Rensselaer, NY.....		
Saratoga, NY.....		
Schenectady, NY.....		
Albuquerque, NM.....	1.0119	1.0081
Bernalillo, NM.....		
Alexandria, LA.....	0.8272	0.8782
Rapides, LA.....		
Allentown-Bethlehem-Easton, PA-NJ.....	0.8945	0.9265
Warren, NJ.....		
Carbon, PA.....		
Lehigh, PA.....		
Northampton, PA.....		
Altoona, PA.....	0.9235	0.9470
Blair, PA.....		
Amarillo, TX.....	0.8735	0.9115
Potter, TX.....		
Randall, TX.....		
*Anaheim-Santa Ana, CA.....	1.1751	1.1168
Orange, CA.....		
Anchorage, AK.....	1.4170	1.2696
Anchorage, AK.....		
Anderson, IN.....	0.9579	0.9710
Madison, IN.....		
Anderson, SC.....	0.7255	0.8027
Anderson, SC.....		
Ann Arbor, MI.....	1.1379	1.0925
Washtenaw, MI.....		
Anniston, AL.....	0.7928	0.8530
Calhoun, AL.....		
Appleton-Oshkosh-Neenah, WI.....	0.9219	0.9458
Calumet, WI.....		
Outagamie, WI.....		
Winnebago, WI.....		
Arecibo, PR.....	0.3952	0.5295
Arecibo, PR.....		
Camuy, PR.....		
Hatillo, PR.....		
Quebradillas, PR.....		
Asheville, NC.....	0.8735	0.9115
Buncombe, NC.....		
Athens, GA.....	0.7770	0.8413
Clarke, GA.....		
Jackson, GA.....		
Madison, GA.....		
Oconee, GA.....		
*Atlanta, GA.....	0.9592	0.9719
Barrow, GA.....		
Butts, GA.....		
Cherokee, GA.....		
Clayton, GA.....		
Cobb, GA.....		
Coweta, GA.....		
De Kalb, GA.....		
Douglas, GA.....		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Fayette, GA.....		
Forsyth, GA.....		
Fulton, GA.....		
Gwinnett, GA.....		
Henry, GA.....		
Newton, GA.....		
Paulding, GA.....		
Rockdale, GA.....		
Spalding, GA.....		
Walton, GA.....		
Atlantic City, NJ.....	1.0604	1.0410
Atlantic, NJ.....		
Cape May, NJ.....		
Augusta, GA-SC.....	0.9397	0.9583
Columbia, GA.....		
McDuffie, GA.....		
Richmond, GA.....		
Aiken, SC.....		
Aurora-Elgin, IL.....	0.9459	0.9624
Kane, IL.....		
Kendall, IL.....		
Austin, TX.....	0.9595	0.9721
Hays, TX.....		
Travis, TX.....		
Williamson, TX.....		
Bakersfield, CA.....	1.0863	1.0583
Kern, CA.....		
*Baltimore, MD.....	1.0151	1.0103
Anne Arundel, MD.....		
Baltimore, MD.....		
Baltimore City, MD.....		
Carroll, MD.....		
Hartford, MD.....		
Howard, MD.....		
Queen Annes, MD.....		
Bangor, ME.....	0.9060	0.9346
Penobscot, ME.....		
Baton Rouge, LA.....	0.9085	0.9364
Ascension, LA.....		
East Baton Rouge, LA.....		
Livingston, LA.....		
West Baton Rouge, LA.....		
Battle Creek, MI.....	0.9095	0.9371
Calhoun, MI.....		
Beaumont-Port Arthur, TX.....	0.9600	0.9724
Hardin, TX.....		
Jefferson, TX.....		
Orange, TX.....		
Beaver County, PA.....	1.0160	1.0109
Beaver, PA.....		
Bellingham, WA.....	1.0492	1.0334
Whatcom, WA.....		
Benton Harbor, MI.....	0.8163	0.8702
Berrien, MI.....		
*Bergen-Passaic, NJ.....	0.8370	0.8853
Bergen, NJ.....		
Passaic, NJ.....		
Billings, MT.....	0.9321	0.9530
Yellowstone, MT.....		
Biloxi-Gulfport, MS.....	0.8059	0.8626
Hancock, MS.....		
Harrison, MS.....		
Binghamton, NY.....	0.9256	0.9484
Broome, NY.....		
Tioga, NY.....		
Birmingham, AL.....	0.8766	0.9138
Blount, AL.....		
Jefferson, AL.....		
Saint Clair, AL.....		
Shelby, AL.....		
Walker, AL.....		
Bismarck, ND.....	0.8878	0.9217
Burleigh, ND.....		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Morton, ND.....		
Bloomington, IN.....	0.7833	0.8460
Monroe, IN.....		
Bloomington-Normal, IL.....	0.8655	0.9058
McLean, IL.....		
Boise City, ID.....	0.9753	0.9830
Ada, ID.....		
*Boston-Lawrence-Salem-Lowell-Brockton, MA.....	1.1804	1.1203
Essex, MA.....		
Middlesex, MA.....		
Norfolk, MA.....		
Plymouth, MA.....		
Suffolk, MA.....		
Boulder-Longmont, CO.....	1.0736	1.0498
Boulder, CO.....		
Bradenton, FL.....	0.8727	0.9110
Manatee, FL.....		
Brazoria, TX.....	0.8943	0.9264
Brazoria, TX.....		
Bremerton, WA.....	0.9631	0.9746
Kitsap, WA.....		
Bridgeport-Stamford-Norwalk-Danbury, CT.....	1.1900	1.1265
Fairfield, CT.....		
Brownsville-Harlingen, TX.....	0.8597	0.9017
Cameron, TX.....		
Bryan-College Station, TX.....	0.9485	0.9644
Brazos, TX.....		
Buffalo, NY.....	0.8905	0.9237
Erie, NY.....		
Burlington, NC.....	0.7936	0.8536
Alamance, NC.....		
Burlington, VT.....	0.9354	0.9553
Chittenden, VT.....		
Grand Isle, VT.....		
Caguas, PR.....	0.4586	0.5863
Caguas, PR.....		
Gurabo, PR.....		
San Lorenzo, PR.....		
Agua Buenas, PR.....		
Cayey, PR.....		
Cidra, PR.....		
Canton, OH.....	0.8449	0.8910
Carroll, OH.....		
Stark, OH.....		
Casper, WY.....	0.8887	0.9224
Natrona, WY.....		
Cedar Rapids, IA.....	0.7528	0.8233
Linn, IA.....		
Champaign-Urbana-Rantoul, IL.....	0.8741	0.9120
Champaign, IL.....		
Charleston, SC.....	0.8328	0.8822
Berkeley, SC.....		
Charleston, SC.....		
Dorchester, SC.....		
Charleston, WV.....	0.9688	0.9785
Kanawha, WV.....		
Putnam, WV.....		
*Charlotte-Gastonia-Rock Hill, NC-SC.....	0.9462	0.9628
Cabarrus, NC.....		
Gaston, NC.....		
Lincoln, NC.....		
Mecklenburg, NC.....		
Rowan, NC.....		
Union, NC.....		
York, SC.....		
Charlottesville, VA.....	0.9611	0.9732
Albermarle, VA.....		
Charlottesville City, VA.....		
Fluvanna, VA.....		
Greene, VA.....		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Chattanooga, TN-GA.....	0.9194	0.9441
Catoosa, GA.....		
Dade, GA.....		
Walker, GA.....		
Hamilton, TN.....		
Marion, TN.....		
Squatchie, TN.....		
Cheyenne, WY.....	0.7773	0.8415
Laramie, WY.....		
*Chicago, IL.....	1.0513	1.0349
Cook, IL.....		
Du Page, IL.....		
McHenry, IL.....		
Chico, CA.....	1.0977	1.0659
Butte, CA.....		
*Cincinnati, OH-KY-IN.....	0.9817	0.9874
Dearborn, IN.....		
Boone, KY.....		
Campbell, KY.....		
Kenton, KY.....		
Clermont, OH.....		
Hamilton, OH.....		
Warren, OH.....		
Clarksville-Hopkinsville, TN-KY.....	0.7379	0.8121
Christian, KY.....		
Montgomery, TN.....		
*Cleveland, OH.....	1.0734	1.0497
Cuyahoga, OH.....		
Geauga, OH.....		
Lake, OH.....		
Medina, OH.....		
Colorado Springs, CO.....	0.9812	0.9671
El Paso, CO.....		
Columbia, MO.....	0.9502	0.9656
Boone, MO.....		
Columbia, SC.....	0.8937	0.9259
Lexington, SC.....		
Richland, SC.....		
Columbus, GA-AL.....	0.7368	0.8113
Russell, AL.....		
Chattahoochee, GA.....		
Muscogee, GA.....		
*Columbus, OH.....	0.9669	0.9772
Delaware, OH.....		
Fairfield, OH.....		
Franklin, OH.....		
Licking, OH.....		
Madison, OH.....		
Pickaway, OH.....		
Union, OH.....		
Corpus Christi, TX.....	0.8590	0.9012
Nueces, TX.....		
San Patricio, TX.....		
Cumberland, MD-WV.....	0.8184	0.8718
Allegany, MD.....		
Mineral, WV.....		
*Dallas, TX.....	0.9634	0.9748
Collin, TX.....		
Dallas, TX.....		
Denton, TX.....		
Ellis, TX.....		
Kaufman, TX.....		
Rockwall, TX.....		
Danville, VA.....	0.7823	0.8452
Danville City, VA.....		
Pittsylvania, VA.....		
Davenport-Rock Island-Moline, IA-IL.....	0.8467	0.8923
Scott, IA.....		
Henry, IL.....		
Rock Island, IL.....		
Dayton-Springfield, OH.....	0.9727	0.9812

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Clark, OH.....		
Greene, OH.....		
Miami, OH.....		
Montgomery, OH.....		
Daytona Beach, FL.....	0.8903	0.9235
Volusia, FL.....		
Decatur, AL.....	0.7484	0.8200
Lawrence, AL.....		
Morgen, AL.....		
Decatur, IL.....	0.8282	0.8789
Macon, IL.....		
*Denver, CO.....	1.0753	1.0510
Adams, CO.....		
Arapahoe, CO.....		
Denver, CO.....		
Douglas, CO.....		
Jefferson, CO.....		
Des Moines, IA.....	0.9167	0.9422
Dallas, IA.....		
Polk, IA.....		
Warren, IA.....		
*Detroit, MI.....	1.0822	1.0556
Lapeer, MI.....		
Livingston, MI.....		
Macomb, MI.....		
Monroe, MI.....		
Oakland, MI.....		
Saint Clair, MI.....		
Wayne, MI.....		
Dothan, AL.....	0.7566	0.8261
Dale, AL.....		
Houston, AL.....		
Dubuque, IA.....	0.8371	0.8854
Dubuque, IA.....		
Duluth, MN-WI.....	0.9513	0.9664
St. Louis, MN.....		
Douglas, WI.....		
Eau Claire, WI.....	0.8484	0.8935
Chippewa, WI.....		
Eau Claire, WI.....		
El Paso, TX.....	0.8710	0.9098
El Paso, TX.....		
Elkhart-Goshen, IN.....	0.7833	0.8460
Elkhart, IN.....		
Elmira, NY.....	0.8848	0.9196
Chemung, NY.....		
Enid, OK.....	0.8909	0.9239
Garfield, OK.....		
Erie, PA.....	0.9151	0.9411
Erie, PA.....		
Eugene-Springfield, OR.....	1.0159	1.0109
Lane, OR.....		
Evansville, IN-KY.....	0.9423	0.9601
Posey, IN.....		
Vanderburgh, IN.....		
Warrick, IN.....		
Henderson, KY.....		
Fargo-Moorhead, ND-MN.....	0.9702	0.9795
Clay, MN.....		
Cass, ND.....		
Fayetteville, NC.....	0.8292	0.8796
Cumberland, NC.....		
Fayetteville-Springdale, AR.....	0.7986	0.8573
Washington, AR.....		
Flint, MI.....	1.1539	1.1030
Genesee, MI.....		
Florence, AL.....	0.7714	0.8372
Colbert, AL.....		
Lauderdale, AL.....		
Florence, SC.....	0.8425	0.8893
Florence, SC.....		
Fort Collins-Loveland, CO.....	1.0234	1.0160
Larimer, CO.....		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
*Fort Lauderdale-Hollywood-Pompano Beach, FL.....	1.0352	1.0240
Broward, FL.....		
Fort Myers-Cape Coral, FL.....	0.9795	0.9859
Lee, FL.....		
Fort Pierce, FL.....	1.1036	1.0698
Martin, FL.....		
St. Lucie, FL.....		
Fort Smith, AR-OK.....	0.7928	0.8530
Crawford, AR.....		
Sebastian, AR.....		
Sequoyah, OK.....		
Fort Walton Beach, FL.....	0.8937	0.9259
Okaloosa, FL.....		
Fort Wayne, IN.....	0.8999	0.9303
Allen, IN.....		
De Kalb, IN.....		
Whitley, IN.....		
*Fort Worth-Arlington, TX.....	0.9743	0.9823
Johnson, TX.....		
Parker, TX.....		
Tarrant, TX.....		
Fresno, CA.....	1.0733	1.0496
Fresno, CA.....		
Gadsden, AL.....	0.8196	0.8726
Etowah, AL.....		
Gainesville, FL.....	0.8795	0.9158
Alachua, FL.....		
Bradford, FL.....		
Galveston-Texas City, TX.....	0.9424	0.9602
Galveston, TX.....		
Gary-Hammond, IN.....	0.9592	0.9719
Lake, IN.....		
Porter, IN.....		
Glens Falls, NY.....	0.9227	0.9464
Warren, NY.....		
Washington, NY.....		
Grand Forks, ND.....	0.9573	0.9706
Grand Forks, ND.....		
Grand Rapids, MI.....	0.9879	0.9917
Kent, MI.....		
Ottawa, MI.....		
Great Falls, MT.....	0.9987	0.9991
Cascade, MT.....		
Greeley, CO.....	0.9354	0.9553
Weid, CO.....		
Green Bay, WI.....	0.9581	0.9711
Brown, WI.....		
Greensboro-Winston-Salem-High Point, NC.....	0.9161	0.9418
Davidson, NC.....		
Davie, NC.....		
Forsyth, NC.....		
Guilford, NC.....		
Randolph, NC.....		
Stokes, NC.....		
Yadkin, NC.....		
Greenville-Spartanburg, SC.....	0.8919	0.9246
Greenville, SC.....		
Pickens, SC.....		
Spartanburg, SC.....		
Hagerstown, MD.....	0.9154	0.9413
Washington, MD.....		
Hamilton-Middletown, OH.....	0.9149	0.9409
Butler, OH.....		
Harrisburg-Lebanon-Carlisle, PA.....	0.9814	0.9941
Cumberland, PA.....		
Dauphin, PA.....		
Lebanon, PA.....		
Perry, PA.....		
*Hartford-Middletown-New Britain-Bristol, CT.....	1.1905	1.1268

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
Hickory, NC	0.8663	0.9064
Alexander, NC		
Burke, NC		
Catawba, NC		
Honolulu, HI	1.1575	1.1053
Honolulu, HI		
Houma-Thibodaux, LA	0.7341	0.8092
Lafourche, LA		
Terrebonne, LA		
*Houston, TX	0.9931	0.9953
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
Huntington-Ashland, WV-KY-OH	0.9434	0.9609
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
Huntsville, AL	0.8831	0.9184
Madison, AL		
*Indianapolis, IN	0.9658	0.9765
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
Iowa City, IA	0.9524	0.9672
Johnson, IA		
Jackson, MI	0.8882	0.9220
Jackson, MI		
Jackson, MS	0.7730	0.8383
Hinds, MS		
Madison, MS		
Rankin, MS		
Jackson, TN	0.8325	0.8820
Madison, TN		
Jacksonville, FL	0.9047	0.9337
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
Jacksonville, FL	0.7936	0.8536
Onslow, NC		
Jamestown-Dunkirk, NY	0.8631	0.7548
Chatauqua, NY		
Janesville-Beloit, WI	0.8443	0.8906
Rock, WI		
Jersey City, NJ	1.0648	1.0439
Hudson, NJ		
Johnson City-Kingsport-Bristol, TN-VA	0.8665	0.9065
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
Johnstown, PA	0.8609	0.9025
Cambria, PA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Somerset, PA		
Joliet, IL	1.0504	1.0342
Grundy, IL		
Will, IL		
Joplin, MO	0.7953	0.8548
Jasper, MO		
Newton, MO		
Kalamazoo, MI	1.1705	1.1138
Kalamazoo, MI		
Kankakee, IL	0.8485	0.8936
Kankakee, IL		
*Kansas City, KS-MO	0.9584	0.9713
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
Kenosha, WI	0.8851	0.9198
Kenosha, WI		
Killeen-Temple, TX	1.1290	1.0866
Bill, TX		
Coryell, TX		
Knoxville, TN	0.8689	0.9083
Anderson, TN		
Blount, TN		
Grainger, TN		
Jefferson, TN		
Knox, TN		
Sevier, TN		
Union, TN		
Kokomo, IN	0.9486	0.9645
Howard, IN		
Tipton, IN		
LaCrosse, WI	0.8952	0.9270
LaCrosse, WI		
Lafayette, LA	0.8223	0.8746
Lafayette, LA		
St. Martin, LA		
Lafayette, IN	0.8619	0.9032
Tippecanoe, IN		
Lake Charles, LA	0.8371	0.8854
Calcasieu, LA		
Lake County, IL	0.9404	0.9588
Lake, IL		
Lakeland-Winter Haven, FL	0.7939	0.8538
Polk, FL		
Lancaster, PA	0.9274	0.9497
Lancaster, PA		
Lansing-East Lansing, MI	1.0218	1.0149
Clinton, MI		
Eaton, MI		
Ingham, MI		
Laredo, TX	0.7275	0.8042
Webb, TX		
Las Cruces, NM	0.7906	0.8514
Dona Ana, NM		
Las Vegas, NV	1.0626	1.0425
Clark, NV		
Lawrence, KS	0.7443	0.8169
Douglas, KS		
Lawton, OK	0.8384	0.8863
Comanche, OK		
Lewiston-Auburn, ME	0.8324	0.8819
Androscoggin, ME		
Lexington-Fayette, KY	0.8443	0.8906
Bourbon, KY		
Clark, KY		
Fayette, KY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Jessamine, KY		
Scott, KY		
Woodford, KY		
Lima, OH	0.8449	0.8910
Allen, OH		
Auglaize, OH		
Lincoln, NE	0.8952	0.9270
Lancaster, NE		
Little Rock-North Little Rock, AR	0.8416	0.8886
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
Longview-Marshall, TX	0.8688	0.9082
Gregg, TX		
Harrison, TX		
Lorain-Elyria, OH	0.8892	0.9227
Lorain, OH		
*Los Angeles-Long Beach, CA	1.2352	1.1556
Los Angeles, CA		
Louisville, KY-IN	0.9088	0.9366
Clark, IN		
Floyd, IN		
Harrison, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
Shelby, KY		
Lubbock, TX	0.8786	0.9152
Lubbock, TX		
Lynchburg, VA	0.8540	0.8976
Amherst, VA		
Campbell, VA		
Lynchburg City, VA		
Macon-Warner Robins, GA	0.8800	0.9162
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Madison, WI	1.0307	1.0209
Dane, WI		
Manchester-Nashua, NH	1.0126	1.0086
Hillsborough, NH		
Merrimack, NH		
Mansfield, OH	0.8389	0.8867
Richland, OH		
Mayaguez, PR	0.4769	0.6023
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
San German, PR		
McAllen-Edinburg-Mission, TX	0.7712	0.8370
Hidalgo, TX		
Medford, OR	1.0041	1.0028
Jackson, OR		
Melbourne-Titusville, FL	0.8727	0.9110
Brevard, FL		
Memphis, TN-AR-MS	0.9056	0.9344
Crittenden, AR		
De Soto, MS		
Shelby, TN		
Tipton, TN		
Merced, CA	1.0310	1.0211
Merced, CA		
*Miami-Hialeah, FL	0.9950	0.9966
Dade, FL		
*Middlesex-Somerset-Hunterdon, NJ	1.0405	1.0276
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Midland, TX	1.0372	1.0253
Midland, TX		
*Milwaukee, WI	0.9715	0.9804
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
*Minneapolis-St. Paul, MN-WI	1.0813	1.0550
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Washington, MN		
Wright, MN		
St. Croix, WI		
Mobile, AL	0.8241	0.8759
Baldwin, AL		
Mobile, AL		
Modesto, CA	1.1383	1.0928
Stanislaus, CA		
Monmouth-Ocean, NJ	0.9940	0.9959
Monmouth, NJ		
Ocean, NJ		
Monroe, LA	0.7880	0.8480
Ouachita, LA		
Montgomery, AL	0.7735	0.8387
Autauga, AL		
Elmore, AL		
Montgomery, AL		
Muncie, IN	0.8427	0.8894
Delaware, IN		
Muskegon, MI	0.9849	0.9896
Muskegon, MI		
Naples, FL	1.0320	1.0218
Collier, FL		
Nashville, TN	0.9393	0.9580
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
*Nassau-Suffolk, NY	1.2149	1.1426
Nassau, NY		
Suffolk, NY		
New Bedford-Fall River-Attleboro, MA	1.1708	1.1140
Bristol, MA		
New Haven-Waterbury-Meriden, CT	1.2090	1.1388
New Haven, CT		
New London-Norwich, CT	1.1566	1.1048
New London, CT		
*New Orleans, LA	0.8985	0.9293
Jefferson, LA		
Orleans, LA		
St. Bernard, LA		
St. Charles, LA		
St. John The Baptist, LA		
St. Tammany, LA		
*New York, NY	1.3455	1.2253
Bronx, NY		
Kings, NY		
New York City, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Rockland, NY		
Westchester, NY		
*Newark, NJ	1.0734	1.0497
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Niagara Falls, NY	0.8398	0.8873
Niagara, NY		
*Norfolk-Virginia Beach-Newport News, VA	0.8511	0.8955
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
James City Co., VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City, VA		
Williamsburg City, VA		
York, VA		
*Oakland, CA	1.4128	1.2670
Alameda, CA		
Contra Costa, CA		
Ocala, FL	0.8611	0.9027
Marion, FL		
Odessa, TX	1.0835	1.0565
Ector, TX		
Oklahoma City, OK	0.9228	0.9465
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
Olympia, WA	1.0997	1.0672
Thurston, WA		
Omaha, NE-IA	0.8985	0.9293
Pottawattamie, IA		
Douglas, NE		
Sarpy, NE		
Washington, NE		
Orange County, NY	0.9193	0.9440
Orange, NY		
*Orlando, FL	0.9617	0.9736
Orange, FL		
Osceola, FL		
Seminole, FL		
Owensboro, KY	0.8148	0.8691
Daviess, KY		
Oxnard-Ventura, CA	1.1787	1.1192
Ventura, CA		
Panama City, FL	0.8629	0.9040
Bay, FL		
Parkersburg-Marietta, WV-OH	0.8536	0.8973
Washington, OH		
Wood, WV		
Pascagoula, MS	0.8767	0.9138
Jackson, MS		
Pensacola, FL	0.8620	0.9033
Escambia, FL		
Santa Rosa, FL		
Peoria, IL	0.8706	0.9095
Peoria, IL		
Tazewell, IL		
Woodford, IL		
*Philadelphia, PA-NJ	1.0947	1.0639
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Bucks, PA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
*Phoenix, AZ	1.0424	1.0288
Maricopa, AZ		
Pine Bluff, AR	0.6976	0.7815
Jefferson, AR		
*Pittsburgh, PA	1.0123	1.0084
Allegheny, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
Pittsfield, MA	1.0778	1.0526
Berkshire, MA		
Ponce, PR	0.4599	0.5875
Juana Diaz, PR		
Ponce, PR		
Portland, ME	0.9253	0.9482
Cumberland, ME		
Sagadahoc, ME		
York, ME		
*Portland, OR	1.1571	1.1051
Clackamas, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Portsmouth-Dover-Rochester, NH	1.0042	1.0029
Rockingham, NH		
Strafford, NH		
Poughkeepsie, NY	1.0443	1.0301
Dutchess, NY		
*Providence-Pawtucket-Woonsocket, RI	1.0291	1.0198
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
Provo-Orem, UT	1.0226	1.0154
Utah, UT		
Pueblo, CO	0.8718	0.9103
Pueblo, CO		
Racine, WI	0.9627	0.9743
Racine, WI		
Raleigh-Durham, NC	0.9461	0.9628
Durham, NC		
Franklin, NC		
Orange, NC		
Wake, NC		
Rapid City, SD	0.8396	0.8872
Pennington, SD		
Reading, PA	1.0267	1.0182
Berks, PA		
Redding, CA	1.0545	1.0370
Shasta, CA		
Reno, NV	1.1613	1.1078
Washoe, NV		
Richland-Kennewick, WA	0.9398	0.9584
Benton, WA		
Franklin, WA		
Richmond-Petersburg, VA	0.9413	0.9594
Charles City Co., VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
*Riverside-San Bernardino, CA	1.1103	1.0743
Riverside, CA		
San Bernardino, CA		
Roanoke, VA	0.8281	0.8788
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
Rochester, MN	1.1025	1.0691
Olmsted, MN		
*Rochester, NY	0.9708	0.9798
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
Rockford, IL	0.9279	0.9500
Boone, IL		
Winnebago, IL		
*Sacramento, CA	1.2257	1.1495
Eldorado, CA		
Placer, CA		
Sacramento, CA		
Yolo, CA		
Saginaw-Bay City-Midland, MI	1.0479	1.0326
Bay, MI		
Midland, MI		
Saginaw, MI		
St. Cloud, MN	0.8915	0.9244
Benton, MN		
Sherburne, MN		
Stearns, MN		
St. Joseph, MO	0.9410	0.9592
Buchanan, MO		
*St. Louis, MO-IL	0.9384	0.9574
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Salem, OR	0.9833	0.9885
Marion, OR		
Polk, OR		
Salinas-Seaside-Monterey, CA	1.3035	1.1990
Monterey, CA		
*Salt Lake City-Ogden, UT	0.9928	0.9951
Davis, UT		
Salt Lake, UT		
Weber, UT		
San Angelo, TX	0.8136	0.8683
Tom Green, TX		
*San Antonio, TX	0.8448	0.8909
Bexar, TX		
Comal, TX		
Guadalupe, TX		
*San Diego, CA	1.1929	1.1284
San Diego, CA		
*San Francisco, CA	1.4521	1.2910
Marin, CA		
San Francisco, CA		
San Mateo, CA		
*San Jose, CA	1.4893	1.3136
Santa Clara, CA		
*San Juan, PR	0.4985	0.6208

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Barcelona, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Lugaillo, PR		
Manati, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Troje Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Santa Barbara-Santa Maria-Lompoc, CA	1.1800	1.1200
Santa Barbara, CA		
Santa Cruz, CA	1.1814	1.1209
Santa Cruz, CA		
Santa Fe, NM	0.9158	0.9415
Los Alamos, NM		
Santa Fe, NM		
Santa Rosa-Petaluma, CA	1.2973	1.1951
Sonoma, CA		
Sarasota, FL	0.9777	0.9487
Sarasota, FL		
Savannah, GA	0.8324	0.8819
Chatham, GA		
Effingham, GA		
Scranton-Wilkes Barre, PA	0.8912	0.9242
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Monroe, PA		
Wyoming, PA		
*Seattle, WA	1.0866	1.0585
King, WA		
Snohomish, WA		
Sharon, PA	0.8910	0.9240
Mercer, PA		
Sheboygan, WI	0.8868	0.9210
Sheboygan, WI		
Sherman-Denison, TX	0.9085	0.9364
Grayson, TX		
Shreveport, LA	0.9295	0.9512
Bossier, LA		
Caddo, LA		
Sioux City, IA-NE	0.8500	0.8947
Woodbury, IA		
Dakota, NE		
Sioux Falls, SD	0.8829	0.9182
Minnehaha, SD		
South Bend-Mishawaka, IN	1.0179	1.0122
St. Joseph, IN		
Spokane, WA	1.0687	1.0466
Spokane, WA		
Springfield, IL	0.9292	0.9510
Menard, IL		
Sangamon, IL		
Springfield, MO	0.8079	0.8641
Christian, MO		
Greene, MO		
Springfield, MA	0.9614	0.9734

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Hampden, MA		
Hampshire, MA		
State College, PA	0.9897	0.9929
Centre, PA		
Steubenville-Weirton, OH-WV	0.8708	0.9096
Jefferson, OH		
Brooke, WV		
Hancock, WV		
Stockton, CA	1.1784	1.1190
San Joaquin, CA		
Syracuse, NY	0.9912	0.9940
Madison, NY		
Onondaga, NY		
Oswego, NY		
Tacoma, WA	0.9631	0.9746
Pierce, WA		
Tallahassee, FL	0.9216	0.9456
Gadsden, FL		
Leon, FL		
*Tampa-St. Petersburg-Clearwater, FL	0.9244	0.9476
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
Terre Haute, IN	0.8823	0.9178
Clay, IN		
Vigo, IN		
Texarkana-TX-Texarkana, AR	0.7903	0.8512
Miller, AR		
Bowie, TX		
Toledo, OH	0.8710	0.9098
Fulton, OH		
Lucas, OH		
Wood, OH		
Topeka, KS	0.9299	0.9514
Shawnee, KS		
Trenton, NJ	1.0034	1.0023
Mercer, NJ		
Tucson, AZ	0.9616	0.9735
Pima, AZ		
Tulsa, OK	0.8573	0.8999
Creeks, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
Tuscaloosa, AL	0.8518	0.8960
Tuscaloosa, AL		
Tyler, TX	0.9833	0.9885
Smith, TX		
Utica-Rome, NY	0.8398	0.8873
Herkimer, NY		
Oneida, NY		
Vallejo-Fairfield-Napa, CA	1.2912	1.1913
Napa, CA		
Solano, CA		
Vancouver, WA	1.0708	1.0480
Clark, WA		
Victoria, TX	0.8990	0.9297
Victoria, TX		
Vineland-Millville-Bridgeton, NJ	0.9645	0.9756
Cumberland, NJ		
Visalia-Tulare-Porterville, CA	1.0388	1.0264
Tulare, CA		
Waco, TX	0.7811	0.8444
McLennan, TX		
*Washington, DC-MD-VA	1.0936	1.0632
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Stafford, VA		
Waterloo-Cedar Falls, IA	0.8639	0.9047
Black Hawk, IA		
Bremmer, IA		
Wausau, WI	0.9744	0.9824
Marathon, WI		
West Palm Beach-Boca Raton-Delray Beach, FL	1.0227	1.0155
Palm Beach, FL		
Wheeling, WV-OH	0.6923	0.7774
Belmont, OH		
Marshall, WV		
Ohio, WV		
Wichita, KS	0.9805	0.9866
Butler, KS		
Harvey, KS		
Sedgwick, KS		
Wichita Falls, TX	0.8169	0.8707
Wichita, TX		
Williamsport, PA	0.8861	0.9205
Lycoming, PA		
Wilmington, DE-NJ-MD	1.0880	1.0595
New Castle, DE		
Cecil, MD		
Salem, NJ		
Wilmington, NC	0.8708	0.9096
New Hanover, NC		
Worcester-Fitchburg-Leominster, MA	0.9682	0.9781
Worcester, MA		
Yakima, WA	1.0107	1.0073
Yakima, WA		
York, PA	0.8609	0.9025
Adams, PA		
York, PA		
Youngstown-Warren, OH	0.9862	0.9905
Mahoning, OH		
Trumbull, OH		
Yuba City, CA	1.0159	1.0109
Sutter, CA		
Yuba, CA		
Yuma, AZ	0.8743	0.9121
Yuma, AZ		

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7130	0.7932
Alaska	1.3492	1.2277
Arizona	0.8743	0.9121
Arkansas	0.6976	0.7815
California	1.0159	1.0109
Colorado	0.8412	0.8883
Connecticut	1.1900	1.1265
Delaware	0.8568	0.8996
Florida	0.8727	0.9110

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Georgia	0.7770	0.8413
Hawaii	0.9614	0.9734
Idaho	0.9101	0.9375
Illinois	0.7696	0.8358
Indiana	0.7833	0.8460
Iowa	0.7528	0.8233
Kansas	0.7443	0.8169
Kentucky	0.7790	0.8428
Louisiana	0.7381	0.8122
Maine	0.8324	0.8819
Maryland	0.8058	0.8626
Massachusetts	1.1708	1.1140
Michigan	0.8882	0.9220
Minnesota	0.8305	0.8806
Mississippi	0.6960	0.7802
Missouri	0.7246	0.8020
Montana	0.8251	0.8766
Nebraska	0.6992	0.7827
Nevada	0.9698	0.9792
New Hampshire	0.9543	0.9685
New Jersey		
New Mexico	0.8317	0.8814
New York	0.8398	0.8873
North Carolina	0.7936	0.8536
North Dakota	0.7715	0.8372
Ohio	0.8449	0.8910
Oklahoma	0.7399	0.8136
Oregon	0.9603	0.9726
Pennsylvania	0.8609	0.9025
Puerto Rico	0.4331	0.5638
Rhode Island		
South Carolina	0.7657	0.8329
South Dakota	0.7165	0.7959
Tennessee	0.7337	0.8089
Texas	0.7592	0.8281
Utah	0.9040	0.9332
Vermont	0.9702	0.9795
Virginia	0.7823	0.8452
Washington	0.9631	0.9746
West Virginia	0.8484	0.8935
Wisconsin	0.8443	0.8906
Wyoming	0.8453	0.8913

* All counties within the State are classified urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to	Wage index	GAF
Abilene, TX	0.9425	0.9603
Akron, OH	0.8917	0.9245
Albany, GA	0.7894	0.8505
Albany-Schenectady-Troy, NY	0.8953	0.9271
Albany-Schenectady-Troy, NY (Rural Vermont Hospitals)	0.9702	0.9795
Albuquerque, NM	0.9938	0.9958
Alexandria, LA	0.8046	0.8617
Allentown-Bethlehem-Easton, PA-NJ	0.8945	0.9265
Altoona, PA	0.9235	0.9470
Amarillo, TX	0.8735	0.9115
Anaheim-Santa Ana, CA	1.1540	1.1031
Anchorage, AK	1.3995	1.2588
Ann Arbor, MI	1.1058	1.0713
Appleton-Oshkosh-Neenah, WI	0.8695	0.9087
Asheville, NC	0.8468	0.8924
Athens, GA	0.7214	0.7996
Athens, GA (Rural Georgia Hospitals)	0.7770	0.8413

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Atlanta, GA	0.9474	0.9637
Augusta, GA-SC	0.9397	0.9583
Aurora-Egin, IL	0.8870	0.9212
Baltimore, MD	1.0151	1.0103
Bangor, ME	0.8797	0.9160
Baton Rouge, LA	0.9085	0.9364
Battle Creek, MI	0.9095	0.9371
Beaver County, PA	0.9447	0.9618
Billings, MT	0.9045	0.9336
Biloxi-Gulfport, MS	0.7801	0.8436
Binghamton, NY	0.8864	0.9207
Birmingham, AL	0.8766	0.9138
Bismarck, ND	0.8878	0.9217
Bloomington, IN	0.7754	0.8401
Bloomington, IN (Rural Indiana Hospitals)	0.7833	0.8460
Boise City, ID	0.9554	0.9692
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1561	1.1044
Boston-Lawrence-Salem-Lowell-Brockton, MA (Rural Massachusetts Hosp)	1.1708	1.1140
Brazoria, TX	0.8789	0.9154
Bremerton, WA	1.0361	1.0246
Buffalo, NY	0.8773	0.9143
Burlington, VT	0.9014	0.9314
Burlington, VT (Rural Vermont Hospitals)	0.9702	0.9795
Caguas, PR	0.4586	0.5863
Canton, OH	0.8062	0.8628
Canton, OH (Rural Ohio Hospitals)	0.8449	0.8910
Casper, WY	0.8769	0.9140
Champaign-Urbana-Rantoul, IL	0.8741	0.9120
Charleston, SC	0.8168	0.8706
Charleston, WV	0.9535	0.9679
Charlotte-Gastonia-Rock Hill, NC-SC	0.9281	0.9502
Charlottesville, VA	0.9370	0.9564
Chattanooga, TN-GA	0.8875	0.9215
Cheyenne, WY	0.7496	0.8209
Chicago, IL	1.0513	1.0349
Chico, CA	1.0845	1.0571
Cincinnati, OH-KY-IN	0.9817	0.9874
Cleveland, OH	1.0470	1.0320
Columbia, MO	0.9265	0.9491
Columbia, SC	0.8745	0.9123
Columbus, GA-AL	0.7368	0.8113
Columbus, OH	0.9515	0.9665
Dallas, TX	0.9634	0.9748
Davenport-Rock Island-Moline, IA-IL	0.8342	0.8833
Dayton-Springfield, OH	0.9727	0.9812
Daytona Beach, FL	0.8903	0.9235
Decatur, AL	0.7484	0.8200
Denver, CO	1.0753	1.0510
Des Moines, IA	0.9028	0.9324
Detroit, MI	1.0740	1.0477
Dothan, AL	0.7566	0.8261
Dubuque, IA	0.8117	0.8669
Dubuque, IA (Rural Wisconsin Hospitals)	0.8443	0.8906
Duluth, MN-WI	0.9390	0.9578
Eau Claire, WI	0.8484	0.8935
El Paso, TX	0.8710	0.9098
Elkhart-Goshen, IN	0.8868	0.9210
Elmira, NY	0.8655	0.9058
Erie, PA	0.9151	0.9411
Eugene-Springfield, OR	1.0159	1.0109
Evansville, IN-KY	0.9068	0.9352
Fargo-Moorhead, ND-MN	0.9312	0.9524
Fayetteville, NC	0.7892	0.8503
Fayetteville, NC (Rural North Carolina)	0.7936	0.8536
Fayetteville-Springdale, AR	0.7986	0.8573

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Flint, MI	1.1203	1.0809
Florence, AL	0.7714	0.8372
Florence, SC	0.8425	0.8893
Fort Collins-Loveland, CO	1.0027	1.0018
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0229	1.0156
Fort Myers-Cape Coral, FL	0.9795	0.9859
Fort Pierce, FL	1.0256	1.0175
Fort Smith, AR	0.7928	0.8530
Fort Walton Beach, FL	0.8937	0.9259
Fort Wayne, IN	0.8724	0.9108
Fort Worth-Arlington, TX	0.9743	0.9823
Fresno, CA	1.0619	1.0420
Galveston-Texas City, TX	0.9424	0.9602
Glens Falls, NY	0.8985	0.9293
Grand Forks, ND	0.9205	0.9449
Grand Rapids, MI	0.9879	0.9917
Great Falls, MT	0.9258	0.9486
Greeley, CO	0.8952	0.9270
Green Bay, WI	0.9274	0.9497
Greensboro-Winston-Salem-High Point, NC	0.8988	0.9295
Greenville-Spartanburg, SC	0.8772	0.9142
Hagerstown, MD	0.8754	0.9129
Hamilton-Middletown, OH	0.8431	0.8897
Harrisburg-Lebanon-Carlisle, PA	0.9386	0.9575
Hartford-Middletown-New Britain-Bristol, CT	1.1803	1.1202
Hickory, NC	0.8421	0.8890
Honolulu, HI	1.1575	1.1053
Houston, TX	0.9931	0.9953
Huntington-Ashland, WV-KY-OH	0.9251	0.9481
Huntsville, AL	0.8477	0.8930
Indianapolis, IN	0.9556	0.9694
Iowa City, IA	0.9323	0.9531
Jackson, MI	0.8822	0.9177
Jackson, MI (Rural Michigan Hospitals)	0.8882	0.9220
Jackson, MS	0.7590	0.8279
Jackson, TN	0.8069	0.8634
Jacksonville, FL	0.9047	0.9337
Johnson City-Kingsport-Bristol-TN-VA	0.8665	0.9065
Johnstown, PA	0.8335	0.8827
Johnstown, PA (Rural Pennsylvania Hosp)	0.8609	0.9025
Joliet, IL	1.0207	1.0141
Joplin, MO	0.7835	0.8461
Kalamazoo, MI	1.1189	1.0800
Kansas City, KS-MO	0.9584	0.9713
Knoxville, TN	0.8689	0.9083
Kokomo, IN	0.9115	0.9385
LaCrosse, WI	0.8743	0.9121
Lafayette, LA	0.8223	0.8746
Lafayette, IN	0.8619	0.9032
Lake Charles, LA	0.8371	0.8854
Lancaster, PA	0.9092	0.9369
Lansing-East Lansing, MI	1.0041	1.0028
Las Vegas, NV	1.0484	1.0329
Lawrence, KS	0.7501	0.8213
Lawton, OK	0.8282	0.8789
Lewiston-Auburn, ME	0.8454	0.8914
Lexington-Fayette, KY	0.8320	0.8817
Lincoln, NE	0.8458	0.8916
Little Rock-North Little Rock, AR	0.8204	0.8732
Longview-Marshall, TX	0.8517	0.8959
Lorain-Elyria, OH	0.8892	0.9227
Los Angeles-Long Beach, CA	1.2352	1.1556
Louisville, KY-IN	0.8965	0.9279
Lubbock, TX	0.8786	0.9152
Lynchburg, VA	0.8386	0.8864
Macon-Warner Robins, GA	0.8618	0.9032

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Madison, WI	0.9787	0.9854
Manchester-Nashua, NH	1.0126	1.0086
Mansfield, OH	0.8389	0.8867
Mansfield, OH (Rural Ohio Hospitals)	0.8449	0.8910
Medford, OR	0.9880	0.9918
Memphis, TN-AR-MS	0.8769	0.9140
Merced, CA	1.0310	1.0211
Miami-Hialeah, FL	0.9950	0.9966
Middlesex-Somerset-Hunterdon, NJ	0.9923	0.9947
Midland, TX	1.0372	1.0253
Milwaukee, WI	0.9599	0.9724
Minneapolis-St. Paul, MN-WI	1.0813	1.0550
Mobile, AL	0.8241	0.8759
Modesto, CA	1.1383	1.0928
Monroe, LA	0.7860	0.8480
Montgomery, AL	0.7735	0.8387
Muncie, IN	0.8270	0.8780
Nashville, TN	0.9393	0.9580
New London-Norwich, CT	1.1290	1.0866
New Orleans, LA	0.8985	0.9293
New York, NY	1.3455	1.2253
Newark, NJ	1.0613	1.0418
Norfolk-Virginia Beach-Newport News, VA	0.8511	0.8955
Oakland, CA	1.4128	1.2670
Odessa, TX	1.0835	1.0565
Oklahoma City, OK	0.9228	0.9465
Olympia, WA	1.0386	1.0263
Omaha, NE-IA	0.8985	0.9293
Orange County, NY	0.9193	0.9440
Orlando, FL	0.9442	0.9614
Owensboro, KY	0.8148	0.8691
Oxnard-Ventura, CA	1.1787	1.1192
Panama City, FL	0.8629	0.9040
Panama City, FL (Rural Florida Hospitals)	0.8727	0.9110
Parkersburg-Marietta, WV-OH	0.8536	0.8973
Pascagoula, MS	0.8767	0.9138
Peoria, IL	0.8706	0.9095
Philadelphia, PA-NJ	1.0792	1.0536
Phoenix, AZ	1.0424	1.0288
Pine Bluff, AR	0.6976	0.7815
Pittsburgh, PA	0.9950	0.9966
Pittsfield, MA	1.0115	1.0079
Portland, ME	0.9106	0.9379
Portland, OR	1.1416	1.0949
Portsmouth-Dover-Rochester, NH	1.0042	1.0029
Poughkeepsie, NY	0.9960	0.9973
Providence-Pawtucket-Woonsocket, RI	1.0036	1.0025
Provo-Orem, UT	0.9997	0.9998
Pueblo, CO	0.8515	0.8958
Raleigh-Durham, NC	0.9193	0.9440
Rapid City, SD	0.8280	0.8788
Redding, CA	1.0401	1.0273
Reno, NV	1.1433	1.0960
Roanoke, VA	0.8163	0.8702
Rochester, NY	0.9560	0.9697
Rockford, IL	0.9091	0.9368
Sacramento, CA	1.2257	1.1495
Saginaw-Bay City-Midland, MI	1.0206	1.0141
St. Cloud, MN	0.8915	0.9244
St. Louis, MO-IL	0.9236	0.9470
Salem, OR	0.9833	0.9885
Salinas-Seaside-Monterey, CA	1.2893	1.1901
Salt Lake City-Ogden, UT	0.9928	0.9951
San Angelo, TX	0.8136	0.8683
San Antonio, TX	0.8448	0.8909
San Diego, CA	1.1929	1.1284
San Francisco, CA	1.4521	1.2910
San Jose, CA	1.4715	1.3028
San Juan, PR	0.4985	0.6208

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Santa Barbara-Santa Maria-Lompoc, CA	1.1631	1.1090
Santa Fe, NM	0.8852	0.9199
Santa Rosa-Petaluma, CA	1.2973	1.1951
Sarasota, FL	0.9442	0.9614
Scranton-Wilkes Barre, PA	0.8912	0.9242
Seattle, WA	1.0715	1.0484
Sharon, PA	0.8910	0.9240
Sheboygan, WI	0.8719	0.9104
Sherman-Denison, TX	0.8930	0.9254
Shreveport, LA	0.9295	0.9512
Sioux City, IA-NE	0.8320	0.8817
Sioux Falls, SD	0.8629	0.9182
South Bend-Mishawaka, IN	0.9684	0.9783
Spokane, WA	1.0687	1.0466
Springfield, IL	0.9189	0.9437
Springfield, MO	0.7912	0.8518
State College, PA	0.9324	0.9532
Steubenville-Weirton, OH-WV	0.8336	0.8828
Stockton, CA	1.1784	1.1190
Syracuse, NY	0.9510	0.9662
Tacoma, WA	0.9863	0.9906
Tallahassee, FL	0.8849	0.9197
Tampa-St. Petersburg-Clearwater, FL	0.9244	0.9476
Terre Haute, IN	0.8714	0.9100
Texarkana, TX-Texarkana, AR	0.7903	0.8512
Toledo, OH	0.8710	0.9098
Toledo, OH (Rural Michigan Hospitals)	0.8882	0.9220
Topeka, KS	0.9299	0.9514
Tucson, AZ	0.9616	0.9735
Tulsa, OK	0.8427	0.8894
Tuscaloosa, AL	0.8283	0.8790
Tyler, TX	0.9326	0.9533
Vallejo-Fairfield-Napa, CA	1.2716	1.1789
Vancouver, WA	1.0120	1.0082
Victoria, TX	0.8835	0.9187
Waco, TX	0.7811	0.8444
Washington, DC-MD-VA	1.0936	1.0632
Waterloo-Cedar Falls, IA	0.8639	0.9047
Wausau, WI	0.9093	0.9370
West Palm Beach-Boca Raton-Delray Beach, FL	1.0227	1.0155
Wichita, KS	0.9559	0.9696
Wichita Falls, TX	0.8169	0.8707
Williamsport, PA	0.8704	0.9093
Wilmington, NC	0.8296	0.8799
Worcester-Fitchburg-Leominster, MA	0.9682	0.9781
Yakima, WA	0.9981	0.9987
Youngstown-Warren, OH	0.9503	0.9657
Rural California	0.9997	0.9998
Rural Connecticut	1.1576	1.1054
Rural Georgia	0.7770	0.8413
Rural Illinois	0.7696	0.8358
Rural Indiana	0.7833	0.8460
Rural Iowa	0.7528	0.8233
Rural Kansas	0.7443	0.8169
Rural Kentucky	0.7790	0.8428
Rural Louisiana	0.7381	0.8122
Rural Michigan	0.8882	0.9220
Rural Minnesota	0.8305	0.8806
Rural Missouri	0.7246	0.8020
Rural New Hampshire	0.9543	0.9685
Rural New Hampshire (Rural Vermont Hosp)	0.9702	0.9795
Rural North Carolina	0.7936	0.8536
Rural Ohio	0.8449	0.8910
Rural Oklahoma	0.7399	0.8136
Rural Pennsylvania	0.8609	0.9025
Rural South Dakota	0.7165	0.7959
Rural Tennessee	0.7337	0.8089
Rural Texas	0.7592	0.8281
Rural Utah	0.9040	0.9332

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Rural Virginia	0.7823	0.8452
Rural Washington	0.9425	0.9603
Rural Washington (Rural Oregon Hosp)	0.9603	0.9726
Rural West Virginia	0.8484	0.8935
Rural Wisconsin	0.8443	0.8906
Rural Wyoming	0.8285	0.8791

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	12.8965
Agua Dulce, PR	6.3891
Akron, OH	12.2791
Albany, GA	11.2600
Albany-Schenectady-Troy, NY	12.4806
Albuquerque, NM	14.1605
Alexandria, LA	11.5753
Allentown-Bethlehem-Easton, PA-NJ	13.7884
Altoona, PA	12.9225
Amarillo, TX	12.2235
Anaheim-Santa Ana, CA	16.9674
Anchorage, AK	19.8289
Anderson, IN	13.4045
Anderson, SC	10.1524
Ann Arbor, MI	15.9236
Anniston, AL	11.0938
Appleton-Oshkosh-Neenah, WI	12.8388
Arecibo, PR	5.5300
Asheville, NC	12.2240
Athens, GA	11.9635
Atlanta, GA	13.4224
Atlantic City, NJ	14.6966
Augusta, GA-SC	13.1493
Aurora-Elgin, IL	13.5186
Austin, TX	13.4267
Bakersfield, CA	15.2019
Baltimore, MD	14.2056
Bangor, ME	12.6780
Baton Rouge, LA	12.7130
Battle Creek, MI	13.2392
Beaumont-Port Arthur, TX	13.4335
Beaver County, PA	14.2180
Bellingham, WA	14.8926
Benton Harbor, MI	11.8274
Bergen-Passaic, NJ	14.4089
Billings, MT	13.0434
Biloxi-Gulfport, MS	11.2771
Binghamton, NY	12.9526
Birmingham, AL	12.2666
Bismarck, ND	12.3267
Bloomington, IN	12.0838
Bloomington-Normal, IL	12.1113
Boise City, ID	13.6480
Boston-Lawrence-Salem-Lowell-Brockton, MA	16.5188
Boulder-Longmont, CO	14.1963
Bradenton, FL	12.9557
Brazoria, TX	13.0281
Bremerton, WA	13.3376
Bridgeport-Stamford-Norwalk-Danbury, CT	16.8305
Brownsville-Harlingen, TX	12.0309
Bryan-College Station, TX	13.2727
Buffalo, NY	12.4609
Burlington, NC	11.1706
Burlington, VT	13.0898
Caguas, PR	6.2649

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Canton, OH	12.3253
Casper, WY	12.4361
Cedar Rapids, IA	12.4596
Champaign-Urbana-Rantoul, IL	12.2322
Charleston, SC	11.6535
Charleston, WV	13.5576
Charlotte-Gastonia-Rock Hill, NC-SC	13.2414
Charlottesville, VA	13.4492
Chattanooga, TN-GA	12.8660
Cheyenne, WY	11.0616
Chicago, IL	14.7119
Chico, CA	15.3604
Cincinnati, OH-KY-IN	13.7371
Clarksville-Hopkinsville, TN-KY	10.3256
Cleveland, OH	15.0210
Colorado Springs, CO	13.7311
Columbia, MO	13.2974
Columbia, SC	12.5055
Columbus, GA-AL	10.4663
Columbus, OH	13.5306
Corpus Christi, TX	12.0212
Cumberland, MD-WV	11.4529
Dallas, TX	13.4814
Danville, VA	10.4995
Davenport-Rock Island-Moline, IA-IL	11.8485
Dayton-Springfield, OH	13.5646
Daytona Beach, FL	12.5096
Decatur, AL	10.4723
Decatur, IL	11.5902
Denver, CO	15.0478
Des Moines, IA	12.8279
Detroit, MI	15.1409
Dothan, AL	10.5672
Dubuque, IA	11.7141
Duluth, MN-WI	13.3127
Eau Claire, WI	11.8584
El Paso, TX	12.1891
Elkhart-Goshen, IN	12.5172
Elmira, NY	12.3239
Enid, OK	12.4665
Erie, PA	12.8062
Eugene-Springfield, OR	14.2167
Evansville, IN-KY	13.1857
Fargo-Moorhead, ND-MN	13.5774
Fayetteville, NC	11.6037
Fayetteville-Springdale, AR	11.1760
Flint, MI	16.1489
Florence, AL	10.7414
Florence, SC	11.7898
Fort Collins-Loveland, CO	14.3206
Fort Lauderdale-Hollywood-Pompano Beach, FL	14.4860
Fort Myers-Cape Coral, FL	13.7065
Fort Pierce, FL	15.4435
Fort Smith, AR-OK	11.0943
Fort Walton Beach, FL	12.4721
Fort Wayne, IN	12.5931
Fort Worth-Arlington, TX	13.6344
Fresno, CA	15.0188
Gadsden, AL	11.4686
Gainesville, FL	12.3072
Galveston-Texas City, TX	13.1915
Gary-Hammond, IN	13.8130
Glens Falls, NY	12.9117
Grand Forks, ND	13.3966
Grand Rapids, MI	13.8241
Great Falls, MT	13.9760
Greeley, CO	13.0898
Green Bay, WI	13.4079
Greensboro-Winston-Salem-High Point, NC	12.8197
Greenville-Spartanburg, SC	12.4814
Hagerstown, MD	12.8093
Hamilton-Middletown, OH	13.1268
Harrisburg-Lebanon-Carlisle, PA	13.8739
Hartford-Middletown-New Britain-Bristol, CT	16.6679

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Hickory, NC	12.2271
Honolulu, HI	16.1983
Houma-Thibodaux, LA	10.2729
Houston, TX	13.8967
Huntington-Ashland, WV-KY-OH	13.2013
Huntsville, AL	12.3581
Indianapolis, IN	13.5158
Iowa City, IA	13.3273
Jackson, MI	13.5173
Jackson, MS	10.8165
Jackson, TN	11.0644
Jacksonville, FL	12.6501
Jacksonville, NC	10.0072
Jamestown-Dunkirk, NY	10.8192
Janesville-Beloit, WI	11.8416
Jersey City, NJ	14.7239
Johnson City-Kingsport-Bristol, TN-VA	12.1249
Johnstown, PA	12.5941
Joliet, IL	14.3772
Joplin, MO	11.1297
Kalamazoo, MI	16.3790
Kankakee, IL	11.8736
Kansas City, KS-MO	13.4119
Kenosha, WI	12.3859
Killeen-Temple, TX	15.7993
Knoxville, TN	12.1590
Kokomo, IN	13.2741
La Crosse, WI	12.5272
Lafayette, LA	11.5076
Lafayette, IN	12.0615
Lake Charles, LA	11.7138
Lake County, IL	13.9788
Lakeland-Winter Haven, FL	11.6521
Lancaster, PA	12.9499
Lansing-East Lansing, MI	14.2990
Laredo, TX	10.1800
Las Cruces, NM	11.0633
Las Vegas, NV	14.8703
Lawrence, KS	12.5003
Lawton, OK	11.7329
Lewiston-Auburn, ME	12.6689
Lexington-Fayette, KY	11.8143
Lima, OH	11.2775
Lincoln, NE	12.5260
Little Rock-North Little Rock, AR	11.7777
Longview-Marshall, TX	12.1572
Lorain-Elyria, OH	12.5459
Los Angeles-Long Beach, CA	17.2810
Louisville, KY-IN	12.7172
Lubbock, TX	12.2947
Lynchburg, VA	11.9507
Macon-Warner Robins, GA	12.3144
Madison, WI	14.4229
Manchester-Nashua, NH	14.3525
Mansfield, OH	11.7387
Mayaguez, PR	6.6740
McAllen-Edinburg-Mission, TX	10.7920
Medford, OR	14.0511
Melbourne-Titusville, FL	12.8679
Memphis, TN-AR-MS	12.6726
Merced, CA	14.4242
Miami-Hialeah, FL	14.2513
Middlesex-Somerset-Hunterdon, NJ	14.5485
Midland, TX	14.5148
Milwaukee, WI	13.5945
Minneapolis-St. Paul, MN-WI	15.1320
Mobile, AL	11.6369
Modesto, CA	16.1936
Monmouth-Ocean, NJ	13.8730
Monroe, LA	10.9996
Montgomery, AL	10.8242
Muncie, IN	11.7931
Muskegon, MI	13.3830
Naples, FL	14.4410
Nashville, TN	13.1448
Nassau-Suffolk, NY	18.0971
New Bedford-Fall River-Attleboro, MA	13.9910

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
New Haven-Waterbury-Meriden, CT.....	16.9179
New London-Norwich, CT.....	16.1857
New Orleans, LA.....	12.5738
New York, NY.....	18.8279
Newark, NJ.....	15.7113
Niagara Falls, NY.....	11.7272
Norfolk-Virginia Beach-Newport News, VA.....	11.9106
Oakland, CA.....	19.9782
Ocala, FL.....	12.0496
Odessa, TX.....	15.1305
Oklahoma City, OK.....	12.9135
Olympia, WA.....	15.3889
Omaha, NE-IA.....	12.5738
Orange County, NY.....	13.5021
Orlando, FL.....	13.4573
Owensboro, KY.....	11.3504
Oxnard-Ventura, CA.....	17.2175
Panama City, FL.....	12.0750
Parkersburg-Marietta, WV-OH.....	11.9450
Pascagoula, MS.....	12.2466
Pensacola, FL.....	12.0624
Peoria, IL.....	12.1828
Philadelphia, PA-NJ.....	15.3190
Phoenix, AZ.....	14.5873
Pine Bluff, AR.....	11.0111
Pittsburgh, PA.....	14.1661
Pittsfield, MA.....	15.0819
Ponce, PR.....	6.4363
Portland, ME.....	12.9972
Portland, OR.....	16.1919
Portsmouth-Dover-Rochester, NH.....	14.0996
Poughkeepsie, NY.....	14.6131
Providence-Pawtucket-Woonsocket, RI.....	14.8684
Provo-Orem, UT.....	14.3096
Pueblo, CO.....	12.2002
Racine, WI.....	12.3782
Raleigh-Durham, NC.....	13.2395
Rapid City, SD.....	11.7497
Reading, PA.....	12.3287
Redding, CA.....	14.7558
Reno, NV.....	16.2510
Richland-Kennewick, WA.....	13.1513
Richmond-Petersburg, VA.....	13.1726
Riverside-San Bernardino, CA.....	15.6107
Roanoke, VA.....	11.5877
Rochester, MN.....	15.4279
Rochester, NY.....	13.5825
Rockford, IL.....	12.9846
Sacramento, CA.....	17.1232
Saginaw-Bay City-Midland, MI.....	14.6188
St. Cloud, MN.....	13.1769
St. Joseph, MO.....	13.1676
St. Louis, MO-IL.....	13.1322
Salem, OR.....	14.6104
Salinas-Seaside-Monterey, CA.....	18.2410
Salt Lake City-Ogden, UT.....	13.8926
San Angelo, TX.....	11.3852
San Antonio, TX.....	11.8222
San Diego, CA.....	16.6930
San Francisco, CA.....	20.3365
San Jose, CA.....	20.8415

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
San Juan, PR.....	6.9756
Santa Barbara-Santa Maria-Lompoc, CA.....	16.4615
Santa Cruz, CA.....	17.8823
Santa Fe, NM.....	12.7832
Santa Rosa-Petaluma, CA.....	18.1542
Sarasota, FL.....	13.6812
Savannah, GA.....	11.6480
Scranton-Wilkes Barre, PA.....	12.5217
Seattle, WA.....	15.2062
Sharon, PA.....	12.6742
Sheboygan, WI.....	12.4098
Sherman-Denison, TX.....	12.7131
Shreveport, LA.....	13.0076
Sioux City, IA-NE.....	11.8949
Sioux Falls, SD.....	12.3553
South Bend-Mishawaka, IN.....	14.2436
Spokane, WA.....	14.9550
Springfield, IL.....	13.0023
Springfield, MO.....	11.3051
Springfield, MA.....	14.4511
State College, PA.....	13.8497
Steubenville-Weirton, OH-WV.....	12.1860
Stockton, CA.....	16.2434
Syracuse, NY.....	13.8711
Tacoma, WA.....	14.4318
Tallahassee, FL.....	12.8971
Tampa-St. Petersburg-Clearwater, FL.....	12.9357
Terre Haute, IN.....	12.3463
Texarkana-TX-Texarkana, AR.....	11.0389
Toledo, OH.....	14.1229
Topeka, KS.....	13.0121
Trenton, NJ.....	14.0413
Tucson, AZ.....	13.4151
Tulsa, OK.....	11.9967
Tuscaloosa, AL.....	11.9195
Tyler, TX.....	13.7607
Utica-Rome, NY.....	11.9069
Vallejo-Fairfield-Napa, CA.....	18.4685
Vancouver, WA.....	15.1047
Victoria, TX.....	12.5802
Vineland-Millville-Bridgeton, NJ.....	13.6515
Visalia-Tulare-Porterville, CA.....	14.5366
Waco, TX.....	10.9308
Washington, DC-MD-VA.....	15.3037
Waterloo-Cedar Falls, IA.....	12.0885
Wausau, WI.....	13.6355
West Palm Beach-Boca Raton-Delray Beach, FL.....	14.1762
Wheeling, WV-OH.....	11.2840
Wichita, KS.....	13.7212
Wichita Falls, TX.....	11.4308
Williamsport, PA.....	12.3992
Wilmington, DE-NJ-MD.....	15.2032
Wilmington, NC.....	12.1861
Worcester-Fitchburg-Leominster, MA.....	15.1431
Yakima, WA.....	14.1430
York, PA.....	12.6185
Youngstown-Warren, OH.....	13.8000
Yuba City, CA.....	14.3528
Yuma, AZ.....	12.4286

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama.....	9.9782
Alaska.....	18.7800
Arizona.....	12.2352
Arkansas.....	9.7615
California.....	14.2158
Colorado.....	11.7715
Connecticut.....	16.6527
Delaware.....	11.9902
Florida.....	12.2119
Georgia.....	10.8640
Hawaii.....	13.4534
Idaho.....	12.5228
Illinois.....	10.7702
Indiana.....	10.9616
Iowa.....	10.5352
Kansas.....	10.4157
Kentucky.....	10.9009
Louisiana.....	10.3290
Maine.....	11.6490
Maryland.....	11.2762
Massachusetts.....	16.3011
Michigan.....	12.4296
Minnesota.....	11.6218
Mississippi.....	9.7401
Missouri.....	10.1393
Montana.....	11.5467
Nebraska.....	9.7847
Nevada.....	13.5711
New Hampshire.....	13.3536
New Jersey ¹	
New Mexico.....	11.6391
New York.....	11.7524
North Carolina.....	11.1061
North Dakota.....	10.7966
Ohio.....	11.8238
Oklahoma.....	10.3540
Oregon.....	13.4376
Pennsylvania.....	12.0476
Puerto Rico.....	6.0612
Rhode Island ¹	
South Carolina.....	10.7144
South Dakota.....	10.0267
Tennessee.....	10.2677
Texas.....	10.6238
Utah.....	12.5646
Vermont.....	12.6386
Virginia.....	10.9323
Washington.....	13.4773
West Virginia.....	11.8723
Wisconsin.....	11.8155
Wyoming.....	11.8294

¹ All counties within the State are classified urban.

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	11.3	15.8	34
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.2324	15.1	34
3	01	SURG	CRANIOTOMY AGE 0-17	3.1311	12.7	36
4	01	SURG	SPINAL PROCEDURES	2.9627	12.8	32
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	2.3812	6.5	28
			1.5504			
6	01	SURG	CARPAL TUNNEL RELEASE	.5437	3.0	22
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	2.8363	21.5	34
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	.7944	4.5	26
9	01	MED	SPINAL DISORDERS & INJURIES	1.2786	10.0	29
10	01	MED	NERVOUS SYSTEM NEOPLASMS WITH CC	1.2884	10.9	30
				4.3	6.2	27
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.9550	9.9	30
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8336	8.2	30
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	1.2160	9.8	30
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	.6662	5.2	27
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS			
				1.1086	9.0	30
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	.8424	5.7	27
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.9170	7.7	29
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	.5958	5.4	27
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	2.0042	12.6	32
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS			
21	01	MED	VIRAL MENINGITIS	1.4505	9.5	30
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.7261	5.4	27
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8202	6.0	27
24	01	MED	SEIZURE & HEADACHE AGE >17 WITH CC	.9714	7.2	28
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5282	4.3	26
				4.0	5.9	27
26	01	MED	SEIZURE & HEADACHE AGE 0-17	1.0516	8.2	27
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3744	9.3	29
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	1.2208	4.6	26
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.5885	2.0	17
30	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3593		
				4.4	6.4	27
31	01	MED	CONCUSSION AGE >17 WITH CC	.7707	3.6	25
32	01	MED	CONCUSSION AGE >17 W/O CC	.4454	1.6	9
33	01	MED	CONCUSSION AGE 0-17	.2494	8.5	29
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	1.1442	4.9	27
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5590		

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.

NOTE: ARITHMETIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG	RETINAL PROCEDURES	.6238	1.9	2.3	11
37	02	SURG	ORBITAL PROCEDURES	.7883	2.8	4.2	26
38	02	SURG	PRIMARY IRIS PROCEDURES	.3584	2.1	2.8	16
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.4858	1.5	1.9	8
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.5150	2.0	3.2	25
41	02	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3713	1.6	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.5968	1.9	2.5	14
43	02	MED	HYPHEMA	.4026	3.6	4.8	27
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.5767	5.2	6.2	28
45	02	MED	NEUROLOGICAL EYE DISORDERS	.5989	3.5	4.4	26
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/CC	.7217	4.3	6.3	27
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/D CC	.4156	2.9	4.1	26
48	02	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.4079	2.9	2.9	26
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.6029	5.0	7.3	28
50	03	SURG	SIALOADENECTOMY	.6594	2.0	2.5	12
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6278	2.1	2.9	19
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7859	2.2	2.9	19
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.7237	2.0	3.1	24
54	03	SURG	* SINUS & MASTOID PROCEDURES AGE 0-17	.6994	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.5469	1.7	2.4	15
56	03	SURG	RHINOPLASTY	.6168	1.9	2.6	17
57	03	SURG	T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8845	3.3	5.1	26
58	03	SURG	* T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3145	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.4273	1.5	2.0	10
60	03	SURG	* TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2655	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	.8613	2.5	4.6	26
62	03	SURG	* MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3136	1.3	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.0429	3.7	5.5	27
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1039	5.1	8.8	28
65	03	MED	DYSEQUILIBRIUM	.4922	3.3	4.1	23
66	03	MED	EPISTAXIS	.4885	3.3	4.3	25
67	03	MED	EPIGLOTTITIS	.8424	4.1	5.2	27
68	03	MED	OTITIS MEDIA & URI AGE >17 WITH CC	.7216	4.7	5.8	28
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5000	3.6	4.3	22
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.6126	3.2	4.4	26

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED	LARYNGOTRACHEITIS		.7664	4.0	5.1	27
72	03	MED	NASAL TRAUMA & DEFORMITY		.5844	3.3	5.0	26
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17		.7522	4.1	5.9	27
74	03	MED	* OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17		.3480	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES		3.0400	11.2	13.6	34
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC		2.3973	10.5	14.6	34
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC		1.0208	4.3	6.5	27
78	04	MED	PULMONARY EMBOLISM		1.4350	8.5	10.0	31
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC		1.7510	9.0	11.8	32
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC		.9617	6.4	7.9	29
81	04	MED	* RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17		1.1200	6.1	6.1	29
82	04	MED	RESPIRATORY NEOPLASMS		1.2809	6.7	9.6	30
83	04	MED	MAJOR CHEST TRAUMA WITH CC		.9490	6.0	7.9	29
84	04	MED	MAJOR CHEST TRAUMA W/O CC		.4783	3.4	4.3	26
85	04	MED	PLEURAL EFFUSION WITH CC		1.1969	6.8	9.0	30
86	04	MED	PLEURAL EFFUSION W/O CC		.6711	4.0	5.3	27
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE		1.3597	5.8	8.0	29
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE		.9941	5.8	7.2	29
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC		1.1581	7.0	8.6	30
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC		.7090	5.2	6.1	28
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17		.7985	4.7	5.8	28
92	04	MED	INTERSTITIAL LUNG DISEASE WITH CC		1.1975	6.8	8.7	30
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC		.7723	4.8	6.0	28
94	04	MED	PNEUMOTHORAX WITH CC		1.2774	7.1	9.3	30
95	04	MED	PNEUMOTHORAX W/O CC		.5973	4.3	5.3	27
96	04	MED	BRONCHITIS & ASTHMA AGE >17 WITH CC		.9369	5.8	7.0	29
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC		.6191	4.3	5.1	24
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17		.8924	4.7	6.3	28
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS WITH CC		.7623	3.8	5.0	27
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC		.5049	2.5	3.1	17
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC		.9135	5.0	6.7	28
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC		.5426	3.3	4.3	26
103	05	SURG	HEART TRANSPLANT		12.5568	23.7	32.3	47
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH		7.7521	17.2	20.1	40
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH		5.8291	11.9	14.3	35

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	5.6583	13.3	14.9	36
107	05	SURG	4.2348	10.2	11.4	33
108	05	SURG	5.8725	12.3	15.1	35
109			.0000	.0	.0	0
110	05	SURG	4.0823	9.9	13.3	33
111	05	SURG	2.2979	7.3	8.4	30
112	05	SURG	1.9874	4.5	6.0	28
113	05	SURG	2.7789	14.0	18.8	37
114	05	SURG	1.5957	8.9	12.3	32
115	05	SURG	3.6092	11.3	13.6	34
116	05	SURG	2.4604	5.3	7.1	28
117	05	SURG	1.2284	3.7	5.4	27
118	05	SURG	1.5858	2.5	3.9	26
119	05	SURG	.9650	3.5	6.0	26
120	05	SURG	1.9906	7.2	12.3	30
121	05	MED	1.6114	7.8	9.5	31
122	05	MED	1.1532	5.7	6.8	29
123	05	MED	1.4090	2.9	5.3	26
124	05	MED	1.2029	4.2	5.7	27
125	05	MED	.7587	2.2	3.1	22
126	05	MED	2.8464	15.5	20.3	39
127	05	MED	1.0150	5.9	7.6	29
128	05	MED	.7873	7.2	8.2	30
129	05	MED	1.2831	2.4	4.7	25
130	05	MED	.9106	6.1	7.9	29
131	05	MED	.5861	4.7	6.0	28
132	05	MED	.7591	4.0	5.4	27
133	05	MED	.5312	2.9	3.8	24
134	05	MED	.5655	3.8	4.8	27
135	05	MED	.8625	4.6	6.4	28
136	05	MED	.5266	3.1	4.2	24
137	05	MED	.6411	3.3	3.3	26
138	05	MED	.8110	4.3	5.7	27
139	05	MED	.5020	2.9	3.6	21
140	05	MED	.6219	3.6	4.4	24

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.6998	5.5	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5048	3.8	22
143	05	MED	CHEST PAIN	.5184	3.3	18
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0650	7.0	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6240	4.1	26
146	06	SURG	RECTAL RESECTION WITH CC	2.5394	13.6	35
147	06	SURG	RECTAL RESECTION W/O CC	1.5192	9.0	31
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.1353	15.6	36
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4948	8.3	28
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.5484	13.7	34
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.1885	6.3	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.7736	8.8	32
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0426	6.5	25
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	4.0491	14.0	37
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.4617	7.2	30
156	06	SURG	* STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8510	6.0	29
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9575	4.5	27
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.4975	2.3	17
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE > 17 WITH CC	1.0747	4.7	28
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE > 17 W/O CC	.6168	2.7	19
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE > 17 WITH CC	.7820	3.2	26
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE > 17 W/O CC	.4651	1.8	11
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.4843	2.3	14
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.1607	9.5	32
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2080	6.3	25
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.3251	5.9	29
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.7495	3.6	15
168	03	SURG	MOUTH PROCEDURES WITH CC	.9902	3.4	26
169	03	SURG	MOUTH PROCEDURES W/O CC	.5788	2.1	18
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7310	10.7	34
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.0898	5.0	28
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.2990	7.1	30
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6346	3.5	27
174	06	MED	G.I. HEMORRHAGE WITH CC	.9794	5.3	28
175	06	MED	G.I. HEMORRHAGE W/O CC	.5506	4.3	22

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	1.0331	5.8	7.5	29
177	06	MED	.7931	5.0	6.1	28
178	06	MED	.5720	3.7	4.4	22
179	06	MED	1.1044	7.0	9.1	30
180	06	MED	.9279	5.7	7.4	29
181	06	MED	.5007	3.8	4.5	25
182	06	MED	.7721	4.8	6.1	28
183	06	MED	.5296	3.4	4.2	24
184	06	MED	.5625	3.0	4.1	25
185	03	MED	.7854	4.4	6.2	27
186	03	MED	.4174	2.9	2.9	23
187	03	MED	.5650	2.6	3.8	26
188	06	MED	.9971	5.2	7.3	28
189	06	MED	.4804	2.8	3.8	26
190	06	MED	.6796	4.1	5.3	27
191	07	SURG	4.4652	15.3	19.9	38
192	07	SURG	1.7051	7.7	9.5	31
193	07	SURG	3.0376	13.7	16.4	37
194	07	SURG	1.6333	7.9	9.8	31
195	07	SURG	2.2744	10.4	12.0	33
196	07	SURG	1.4039	7.2	8.0	30
197	07	SURG	1.6916	6.2	8.3	29
198	07	SURG	.8757	2.6	3.6	26
199	07	SURG	2.3376	11.0	14.3	34
200	07	SURG	2.7205	9.0	13.4	32
201	07	SURG	2.5221	10.0	14.4	33
202	07	MED	1.2996	7.0	9.6	30
203	07	MED	1.2158	6.8	9.7	30
204	07	MED	1.1158	6.0	7.8	29
205	07	MED	1.2249	6.5	9.1	30
206	07	MED	.6113	3.6	5.0	27
207	07	MED	.9814	5.3	6.9	28
208	07	MED	.5564	3.1	4.0	25
209	08	SURG	2.3686	9.4	10.4	32
210	08	SURG	1.9077	10.7	12.5	34

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.3307	8.3	9.3	31
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.0345	4.2	6.1	27
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7686	9.2	12.8	32
214	08	SURG	BACK & NECK PROCEDURES WITH CC	1.8686	8.1	10.1	31
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0905	5.1	6.0	28
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.0429	10.0	14.5	33
217	08	SURG	WND DEBRID & SKN GRAFT EXCEPT HAND, FOR MUSCULOSKELETAL & CONN TISS DIS	3.0601	13.6	21.3	37
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 WITH CC	1.4186	6.8	8.8	30
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	.8956	4.2	5.1	26
220	08	SURG	* LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	.9382	5.3	5.3	28
221	08	SURG	KNEE PROCEDURES WITH CC	1.7828	7.3	10.6	30
222	08	SURG	KNEE PROCEDURES W/O CC	.8544	3.7	5.2	27
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	.8087	3.0	3.8	22
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	.6538	2.4	2.9	14
225	08	SURG	FOOT PROCEDURES	.8212	3.3	5.0	26
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3241	5.7	8.7	29
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6767	2.8	3.8	23
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	.7961	2.5	3.5	25
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5539	1.9	2.6	15
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.9179	3.9	6.0	27
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1.1044	3.9	6.3	27
232	08	SURG	ARTHROSCOPY	1.1792	3.6	6.6	27
233	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC WITH CC	1.8579	8.3	11.6	31
234	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W/O CC	.8957	3.9	5.3	27
235	08	MED	FRACTURES OF FEMUR	1.0209	6.8	11.2	30
236	08	MED	FRACTURES OF HIP & PELVIS	.8128	6.2	8.6	29
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5496	4.2	5.5	27
238	08	MED	OSTEOMYELITIS	1.5435	10.2	13.7	33
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0415	7.4	9.9	30
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1468	6.8	9.2	30
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5782	4.3	5.6	27
242	08	MED	SEPTIC ARTHRITIS	1.1864	7.8	10.3	31
243	08	MED	MEDICAL BACK PROBLEMS	.6834	5.0	6.7	28
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7353	5.2	7.0	28
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5043	3.8	5.3	27

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED	NON-SPECIFIC ARTHROPATHIES			
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	4.2	5.3	27
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	3.7	5.0	27
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	4.5	6.0	28
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC	4.1	6.2	27
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	4.5	6.5	28
252	08	MED	* FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	2.6	3.5	25
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 WITH CC	1.8	1.8	15
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC	5.5	7.8	29
255	08	MED	* FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0-17	4.231	4.6	26
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	2.9	2.9	26
257	08	MED	TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	3.7	5.2	27
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	4.2	4.9	23
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	3.2	3.5	14
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	3.6	5.4	27
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	2.1	2.5	12
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	2.2	2.8	14
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCE OR CELLULITIS WITH CC	2.1	3.1	22
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCE OR CELLULITIS W/O CC	14.3	20.2	37
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.2662	11.3	31
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	1.3939	9.5	29
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	3.0	4.3	26
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	2.7	4.1	26
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE WITH CC	2.6	4.4	26
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE W/O CC	8.0	12.0	31
271	09	MED	SKIN ULCERS	2.8	3.9	26
272	09	MED	MAJOR SKIN DISORDERS WITH CC	8.4	11.2	31
273	09	MED	MAJOR SKIN DISORDERS W/O CC	7.1	9.2	30
274	09	MED	MALIGNANT BREAST DISORDERS WITH CC	5.2	6.7	28
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	6.7	10.8	30
276	09	MED	NON-MALIGNANT BREAST DISORDERS	3.0	4.8	26
277	09	MED	CELLULITIS AGE >17 WITH CC	4.0	5.4	27
278	09	MED	CELLULITIS AGE >17 W/O CC	6.8	8.2	30
279	09	MED	* CELLULITIS AGE 0-17	5.1	6.0	28
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	4.2	4.2	24
				4.6	6.3	28

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC		4.1	26
282	09	MED	* TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.4270	4.1	26
283	09	MED	MINOR SKIN DISORDERS WITH CC	.3476	2.2	19
284	09	MED	MINOR SKIN DISORDERS W/O CC	.7558	7.1	28
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	.4450	4.7	26
				2.7519	21.1	38
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.3944	11.1	32
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.1744	18.3	36
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0378	10.1	30
289	10	SURG	PARATHYROID PROCEDURES	1.0252	5.3	27
290	10	SURG	THYROID PROCEDURES	.7448	3.2	16
291	10	SURG	THYROID GLAND PROCEDURES	.4896	2.0	9
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.8428	17.7	35
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1284	7.5	28
294	10	MED	DIABETES AGE >35	.7491	7.1	29
295	10	MED	DIABETES AGE 0-35	.7721	5.7	27
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9410	8.1	29
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5271	5.0	27
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.4777	3.4	21
299	10	MED	INSORNS ERRORS OF METABOLISM	.8382	6.7	28
300	10	MED	ENDOCRINE DISORDERS WITH CC	1.1251	9.2	30
301	10	MED	ENDOCRINE DISORDERS W/O CC	.5811	5.3	27
302	11	SURG	KIDNEY TRANSPLANT	3.8885	15.7	37
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6532	13.1	34
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.4103	13.3	33
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1548	6.4	28
306	11	SURG	PROSTATECTOMY WITH CC	1.2744	8.6	30
307	11	SURG	PROSTATECTOMY W/O CC	.8889	4.5	20
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.4315	8.9	29
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.7287	3.9	26
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	.8880	5.4	27
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5153	2.1	14
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	.8082	5.2	27
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.4623	2.1	17
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4389	2.3	25
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0382	12.0	30

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	RENAL FAILURE	1.2896	6.2	9.1	29
317	11	MED	ADMIT FOR RENAL DIALYSIS	.5075	2.8	3.9	26
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.1244	6.0	9.0	29
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5069	2.5	3.7	26
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	.9807	6.5	8.1	29
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.6252	4.8	5.7	27
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6389	4.6	5.6	28
323	11	MED	URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.7381	3.1	4.2	26
324	11	MED	URINARY STONES W/O CC	.3858	2.1	2.5	13
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.6551	4.2	5.7	27
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4152	2.8	3.6	22
327	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.7038	4.9	6.5	28
328	11	MED	URETHRAL STRICTURE AGE >17 WITH CC	.6363	3.6	4.8	27
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4113	2.1	2.9	18
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2830	1.6	1.6	9
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.9765	5.3	7.4	28
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5347	3.0	4.4	26
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.9590	5.2	7.6	28
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.7728	8.2	8.9	28
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3597	6.9	7.3	19
336	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC	.8704	4.6	5.5	24
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6066	3.4	3.8	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.9386	3.9	6.1	27
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.7572	3.1	4.5	26
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4401	2.4	2.4	13
341	12	SURG	PENIS PROCEDURES	.9681	3.3	4.2	25
342	12	SURG	CIRCUMCISION AGE >17	.5766	2.5	3.7	25
343	12	SURG	* CIRCUMCISION AGE 0-17	.3845	1.7	1.7	6
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0568	3.9	5.2	27
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.7521	3.2	4.6	26
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9906	5.7	8.5	29
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5120	2.9	4.4	26
348	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH CC	.6815	4.0	5.5	27
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.3952	2.3	3.0	20
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6707	4.8	5.8	28

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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
351	12	MED	* STERILIZATION, MALE	.3384	1.3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5801	4.7	26
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9031	11.1	32
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.3886	7.8	30
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.8493	5.0	12
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	7030	3.8	15
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.3097	10.0	33
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.1066	5.6	22
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7723	4.2	11
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8024	4.0	27
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.9767	3.5	27
362	13	SURG	* ENDOSCOPIC TUBAL INTERRUPTION	.5057	1.4	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6251	3.0	24
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.5659	2.6	26
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7093	7.1	30
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.2158	6.5	29
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.4808	2.7	26
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8820	5.8	29
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5321	3.1	26
370	14	SURG	CESAREAN SECTION W CC	.8916	5.3	27
371	14	SURG	CESAREAN SECTION W/O CC	.6461	4.0	11
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4619	2.9	19
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3182	2.1	8
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6297	2.8	24
375	14	SURG	* VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6921	4.4	27
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3247	2.3	17
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.3392	3.6	27
378	14	MED	ECTOPIC PREGNANCY	.7694	3.3	13
379	14	MED	THREATENED ABORTION	.2743	2.0	20
380	14	MED	ABORTION W/O D&C	.3430	1.9	20
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.4326	1.7	14
382	14	MED	FALSE LABOR	.1486	1.3	5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3947	4.3	26
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.2701	2.0	18
385	15	MED	* NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2418	1.8	25

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
386	15	MED	* EXTREME IMMATURETY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	17.9	17.9	41
387	15	MED	* PREMATURITY W MAJOR PROBLEMS	3.7035	13.3	36
388	15	MED	* PREMATURITY W/O MAJOR PROBLEMS	1.8545	8.6	32
389	15	MED	* FULL TERM NEONATE W MAJOR PROBLEMS	1.1747	4.7	28
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.4229	5.1	27
				1.1340		
391	15	MED	* NORMAL NEWBORN	.2252	3.1	11
392	16	SURG	* SPLENECTOMY AGE >17	3.1287	14.0	34
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5437	9.1	32
394	16	SURG	* OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.5966	5.6	29
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7881	4.6	28
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	.8802	2.0	24
397	16	MED	COAGULATION DISORDERS	1.1905	5.3	28
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.2091	8.4	29
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.8735	4.0	27
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5572	8.9	32
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.3497	10.2	33
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.8536	3.5	27
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6827	8.1	31
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7428	4.0	27
405	17	MED	* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0565	4.9	28
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.7689	11.0	34
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	1.1999	5.0	28
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC	1.3278	4.9	28
409	17	MED	RADIOTHERAPY	.9888	8.1	29
410	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	.6095	2.8	20
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4258	2.4	23
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4257	2.0	20
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.3335	7.3	30
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.6857	4.1	27
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5162	14.6	38
416	18	MED	SEPTICEMIA AGE >17	1.5222	7.4	30
417	18	MED	SEPTICEMIA AGE 0-17	.8974	4.4	27
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9878	6.4	29
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9500	5.7	29
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6510	4.4	27

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** DRGS 459 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED	VIRAL ILLNESS AGE >17	.6882	5.4	27
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.7629	6.2	28
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.5978	11.0	31
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4058	23.4	37
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.7045	6.2	27
426	19	MED	DEPRESSIVE NEUROSES	.6023	7.2	28
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.6322	7.6	28
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7703	10.5	29
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9460	11.4	31
430	19	MED	PSYCHOSES	.9040	12.3	32
431	19	MED	CHILDHOOD MENTAL DISORDERS	.5980	7.3	28
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7113	6.9	27
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3545	4.4	26
434	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	.7494	7.4	28
435	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	.4818	6.3	27
436	20	MED	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.9869	17.9	38
437	20	MED	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	1.0888	16.7	37
438			NO LONGER VALID	.0000	0	0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.2126	9.2	29
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8359	12.9	31
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7321	3.5	25
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.9106	9.7	29
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.7518	3.7	26
444	21	MED	TRAUMATIC INJURY AGE > 17 W CC	.7643	7.2	28
445	21	MED	TRAUMATIC INJURY AGE > 17 W/O CC	.4849	4.3	26
446	21	MED	* TRAUMATIC INJURY AGE 0-17	.4869	2.4	22
447	21	MED	* ALLERGIC REACTIONS AGE >17	.4919	3.4	24
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3523	2.9	17
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	.7889	5.7	27
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4325	3.2	22
451	21	MED	* POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.5268	2.1	17
452	21	MED	COMPLICATIONS OF TREATMENT WITH CC	.8550	6.1	27
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4175	3.5	23
454	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	.8873	6.8	27
455	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	.4130	3.1	21

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
456	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.7285	8.8	28
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.0147	8.8	27
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.8787	22.7	39
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	1.8906	10.2	33
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0032	9.1	29
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	.8808	5.1	26
462	23	MED	REHABILITATION	1.7805	17.9	37
463	23	MED	SIGNS & SYMPTOMS W CC	.7277	6.6	28
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4567	4.1	26
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.3531	2.8	20
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5328	4.4	25
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4469	5.4	26
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.4195	19.0	36
469			PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470			** UNGROUPABLE	.0000	.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.8976	13.7	35
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.7093	29.9	39
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4402	17.1	33
474	04		NO LONGER VALID	.0000	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.5965	14.1	33
476			PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2014	16.9	37
477			NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.4337	10.2	29
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.1645	10.2	30
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.2718	5.5	27
480			LIVER TRANSPLANT	20.1814	40.3	50
481			BONE MARROW TRANSPLANT	15.2244	45.7	64
482		SURG	TRACHEOSTOMY W MOUTH, LARYNX OR PHARYNX DISORDER	3.4826	18.0	37
483		SURG	TRACHEOSTOMY EXCEPT FOR MOUTH, LARYNX OR PHARYNX DISORDER	16.6590	57.2	67
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.5706	23.3	38
485	24	SURG	LIMB REATTACH., HIP AND FEMUR PROCS FOR MULTI SIGN TRAUMA	3.1669	16.4	36
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8231	17.4	34
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9406	11.3	31
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.1539	23.1	39
489	25	MED	HIV W MAJOR RELATED CONDITION	1.9151	14.1	32
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1285	8.8	28

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TABLE 5

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						RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
491 08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - UPPER EXTREMITY			1.5676	5.3	6.3	28	
492 17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS			2.7815	8.5	14.3	32	

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BILLING CODE 4120-03-C

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
008.00	Intestinal infection due to unspecified <i>E. coli</i>	N	06	182, 183, 184
008.01	Intestinal infection due to enteropathogenic <i>E. coli</i>	N	06	182, 183, 184
008.02	Intestinal infection due to enterotoxigenic <i>E. coli</i>	N	06	182, 183, 184
008.03	Intestinal infection due to enteroinvasive <i>E. coli</i>	N	06	182, 183, 184
008.04	Intestinal infection due to enterohemorrhagic <i>E. coli</i>	N	06	182, 183, 184
008.09	Intestinal infection due to other intestinal <i>E. coli</i> infections	N	06	182, 183, 184
008.43	Intestinal infection due to <i>Campylobacter</i>	N	06	182, 183, 184
008.44	Intestinal infection due to <i>Yersinia enterocolitica</i>	N	06	182, 183, 184
008.45	Intestinal infection due to <i>Clostridium difficile</i>	N	06	182, 183, 184
008.46	Intestinal infection due to other anaerobes	N	06	182, 183, 184
008.47	Intestinal infection due to other gram-negative bacteria	N	06	182, 183, 184
008.61	Enteritis due to Rotavirus	N	06	182, 183, 184
008.62	Enteritis due to Adenovirus	N	06	182, 183, 184
008.63	Enteritis due to Norwalk virus	N	06	182, 183, 184
008.64	Enteritis due to other small round viruses [SRV's]	N	06	182, 183, 184
008.65	Enteritis due to Calicivirus	N	06	182, 183, 184
008.66	Enteritis due to Astrovirus	N	06	182, 183, 184
008.67	Enteritis due to Enterovirus not elsewhere classified	N	06	182, 183, 184
008.69	Enteritis due to other viruses	N	06	182, 183, 184
041.00	Bacterial infection due to unspecified <i>Streptococcus</i>	N	18	423
041.01	Bacterial infection due to <i>Streptococcus</i> , Group A	N	18	423
041.02	Bacterial infection due to <i>Streptococcus</i> , Group B	N	18	423
041.03	Bacterial infection due to <i>Streptococcus</i> , Group C	N	18	423
041.04	Bacterial infection due to <i>Streptococcus</i> , Group D	N	18	423
041.05	Bacterial infection due to <i>Streptococcus</i> , Group G	N	18	423
041.09	Bacterial infection due to other <i>Streptococcus</i>	N	18	423
041.10	Bacterial infection due to unspecified <i>Staphylococcus</i>	N	18	423
041.11	Bacterial infection due to <i>Staphylococcus aureus</i>	N	18	423
041.19	Bacterial infection due to other <i>Staphylococcus</i>	N	18	423
041.81	Bacterial infection due to <i>Mycoplasma</i>	N	18	423
041.82	Bacterial infection due to <i>Bacillus fragilis</i>	N	18	423
041.83	Bacterial infection due to <i>Clostridium perfringens</i>	N	18	423
041.84	Bacterial infection due to other anaerobes	N	18	423
041.85	Bacterial infection due to other gram-negative organisms	N	18	423
041.89	Bacterial infection due to other specified bacteria	N	18	423
099.40	Unspecified nongonococcal urethritis [NGU]	N	12	350
099.41	Venereal urethritis due to <i>Chlamydia trachomatis</i>	N	12	350
099.49	Venereal urethritis due to other specified organism	N	12	350
099.50	<i>Chlamydia trachomatis</i> infection of unspecified site	N	12	350
099.51	<i>Chlamydia trachomatis</i> infection of pharynx	N	03	68, 69, 70
099.52	<i>Chlamydia trachomatis</i> infection of anus and rectum	N	06	188, 189, 190
099.53	<i>Chlamydia trachomatis</i> infection of lower genitourinary sites	N	12	350
099.54	<i>Chlamydia trachomatis</i> infection of other genitourinary sites	N	11	320, 321, 322
099.55	<i>Chlamydia trachomatis</i> infection of unspecified genitourinary site	N	12	350
099.56	<i>Chlamydia trachomatis</i> infection of peritoneum	N	06	188, 189, 190
099.59	<i>Chlamydia trachomatis</i> infection of other specified site	N	12	350
112.84	Candidiasis of the esophagus	Y	08	182, 183, 184
112.85	Candidiasis of the intestine	Y	06	182, 183, 184
320.81	Meningitis due to anaerobic bacteria	Y	01	20
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified	Y	01	20
320.89	Meningitis due to other specified bacteria	Y	01	20
346.00	Classical migraine without mention of intractable migraine	N	01	24, 25, 26
346.01	Classical migraine with intractable migraine, so stated	N	01	24, 25, 26
346.10	Common migraine without mention of intractable migraine	N	01	24, 25, 26
346.11	Common migraine with intractable migraine, so stated	N	01	24, 25, 26
346.20	Variants of migraine without mention of intractable migraine	N	01	24, 25, 26
346.21	Variants of migraine with intractable migraine, so stated	N	01	24, 25, 26
346.80	Other forms of migraine without mention of intractable migraine	N	01	24, 25, 26
346.81	Other forms of migraine with intractable migraine, so stated	N	01	24, 25, 26
346.90	Migraine, unspecified, without mention of intractable migraine	N	01	24, 25, 26
346.91	Migraine, unspecified, with intractable migraine, so stated	N	01	24, 25, 26
371.82	Corneal disorder due to contact lens	N	02	46, 47, 48
437.7	Transient global amnesia	N	01	16, 17
440.20	Atherosclerosis of arteries of the extremities, unspecified	N	05	130, 131
440.21	Atherosclerosis of arteries of the extremities with intermittent claudication	N	05	130, 131
440.22	Atherosclerosis of arteries of the extremities with rest pain	N	05	130, 131

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
482.30	Pneumonia due to unspecified <i>Streptococcus</i>	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
482.31	Pneumonia due to <i>Streptococcus</i> , Group A.....	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
482.32	Pneumonia due to <i>Streptococcus</i> , Group B.....	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
482.39	Pneumonia due to other <i>Streptococcus</i>	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
482.81	Pneumonia due to anaerobes.....	Y	04	79, 80, 81 15 387, 389 ¹ 25 489
482.82	Pneumonia due to <i>Escherichia coli</i> [<i>E. coli</i>].....	Y	04	79, 80, 81 15 387, 389 ¹ 25 489
482.83	Pneumonia due to other gram-negative bacteria.....	Y	04	79, 80, 81 15 387, 389 ¹ 25 489
482.89	Pneumonia due to other specified bacteria.....	Y	04	79, 80, 81 15 387, 389 ¹ 25 489
483.0	Pneumonia due to <i>Mycoplasma pneumoniae</i>	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
483.8	Pneumonia due to other specified organism.....	Y	04	89, 90, 91 15 387, 389 ¹ 25 489
524.00	Unspecified anomaly of jaw size.....	N	03	185, 186, 187 — 482
524.01	Maxillary hyperplasia.....	N	03	185, 186, 187 — 482
524.02	Mandibular hyperplasia.....	N	03	185, 186, 187 — 482
524.03	Maxillary hypoplasia.....	N	03	185, 186, 187 — 482
524.04	Mandibular hypoplasia.....	N	03	185, 186, 187 — 482
524.05	Macrogenia.....	N	03	185, 186, 187 — 482
524.06	Microgenia.....	N	03	185, 186, 187 — 482
524.09	Other specified anomaly of jaw size.....	N	03	185, 186, 187 — 482
524.10	Unspecified anomaly of relationship of jaw to cranial base.....	N	03	185, 186, 187 — 482
524.11	Maxillary asymmetry.....	N	03	185, 186, 187 — 482
524.12	Other jaw asymmetry.....	N	03	185, 186, 187 — 482
524.19	Other specified anomaly of relationship of jaw to cranial base.....	N	03	185, 186, 187 — 482
524.70	Unspecified alveolar anomaly.....	N	03	185, 186, 187 — 482
524.71	Alveolar maxillary hyperplasia.....	N	03	185, 186, 187 — 482
524.72	Alveolar mandibular hyperplasia.....	N	03	185, 186, 187 — 482
524.73	Alveolar maxillary hypoplasia.....	N	03	185, 186, 187 — 482
524.74	Alveolar mandibular hypoplasia.....	N	03	185, 186, 187 — 482
524.79	Other specified alveolar anomaly.....	N	03	185, 186, 187 — 482
596.51	Hypertonicity of bladder.....	N	11	331, 332, 333
596.52	Low bladder compliance.....	N	11	331, 332, 333
596.53	Paralysis of bladder.....	N	11	331, 332, 333
596.54	Neurogenic bladder, not otherwise specified.....	N	11	331, 332, 333
596.55	Detrusor sphincter dyssynergia.....	N	11	331, 332, 333
596.59	Other functional disorder of bladder.....	N	11	331, 332, 333
599.81	Urethral hypermobility.....	N	11	331, 332, 333
599.82	Intrinsic (urethra) sphincter deficiency [ISD].....	N	11	331, 332, 333
599.83	Urethral instability.....	N	11	331, 332, 333
599.84	Other specified disorders of urethral.....	N	11	331, 332, 333
599.89	Other specified disorders of urinary tract.....	N	11	331, 332, 333
659.60	Other advanced maternal age, unspecified as to episode of care or not applicable.....	N	14	370, 371, 372, 373, 374, 375

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
659.61	Other advanced maternal age, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
659.63	Other advanced maternal age, antepartum condition or complication	N	14	383, 384
692.72	Acute dermatitis due to solar radiation	N	09	283, 284
692.73	Actinic reticuloid and actinic granuloma	N	09	283, 284
692.74	Other chronic dermatitis due to solar radiation	N	09	283, 284
692.82	Dermatitis due to other radiation	N	09	283, 284
692.83	Dermatitis due to metals	N	09	283, 284
710.5	Eosinophilia myalgia syndrome	N	08	240, 241
738.10	Unspecified acquired deformity of head	N	08	256
738.11	Zygomatic hyperplasia	N	08	256
738.12	Zygomatic hypoplasia	N	08	256
738.19	Other specified acquired deformity of head	N	08	256
780.01	Coma	Y	01	23
			15	387, 389 ¹
780.02	Transient alteration of awareness	N	01	23
780.09	Other alteration of consciousness	N	01	23
780.57	Other and unspecified sleep apnea	N	01	34, 35
788.30	Unspecified urinary incontinence	N	11	325, 326, 327
788.31	Urge incontinence	N	11	325, 326, 327
788.32	Stress incontinence, male	N	11	325, 326, 327
788.33	Mixed incontinence, urge and stress	N	11	325, 326, 327
788.34	Incontinence without sensory awareness	N	11	325, 326, 327
788.35	Post-void dribbling	N	11	325, 326, 327
788.36	Nocturnal enuresis	N	11	325, 326, 327
788.37	Continuous leakage	N	11	325, 326, 327
788.39	Other urinary incontinence	N	11	325, 326, 327
864.05	Injury to liver without mention of open wound into cavity, unspecified laceration.	Y	07	205, 206
			24	487 ²
864.15	Injury to liver with open wound into cavity, unspecified laceration	Y	07	205, 206
			24	487 ²
V07.4	[Need for] prophylactic postmenopausal hormone replacement therapy	N	23	467
V25.43	[Encounter for] surveillance of implantable subdermal contraceptive	N	23	467
V25.5	[Encounter for] insertion of implantable subdermal contraceptive	N	23	467
V29.0	Observation and evaluation of newborns and infants for suspected infectious condition not found.	N	15	391 ³
			23	467
V29.1	Observation and evaluation of newborns and infants for suspected neurological condition not found.	N	15	391 ³
			23	467
V29.8	Observation and evaluation of newborns and infants for other specified suspected condition not found.	N	15	391 ³
			23	467
V29.9	Observation and evaluation of newborns and infants for unspecified	N	15	391 ³
			23	467

¹ Diagnosis code is classified as a "major problem" in these DRGs.² Diagnosis code is assigned to the "Significant Abdominal Trauma" body site category.³ Diagnosis code is considered in this classification only if it is a secondary diagnosis.

TABLE 6b.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
02.96	Insertion of sphenoidal electrodes	N		
66.01	Salpingotomy	Y	13	354, 355, 357, 358, 359
66.02	Salpingostomy	Y	13	354, 355, 357, 358, 359
68.9	Other and unspecified hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375
81.97	Revision of joint replacement of upper extremity	Y	08	233, 234
			21	442, 443
			24	486

TABLE 6C.—INVALID DIAGNOSIS CODES¹

Diagnosis code	Description	CC	MDC	DRG
008.0	Intestinal infection due to Escherichia coli [E. coli]	N	06	182, 183, 184
008.6	Enteritis due to specified virus	N	06	182, 183, 184
041.0	Bacterial infection due to Streptococcus	N	18	423
041.1	Bacterial infection due to Staphylococcus	N	18	423
041.8	Other specified bacterial infections	N	18	423
099.4	Other nongonococcal urethritis	N	12	350
			13	358, 359, 368
320.8	Meningitis due to other specified bacteria	Y	01	20
			15	387, 389 ²

TABLE 6C.—INVALID DIAGNOSIS CODES ¹—Continued

Diagnosis code	Description	CC	MDC	DRG
346.0	Classical migraine	N	01	24, 25, 26
346.1	Common migraine	N	01	24, 25, 26
346.2	Variants of migraine	N	01	24, 25, 26
346.8	Other forms of migraine	N	01	24, 25, 26
346.9	Migraine, unspecified	N	01	24, 25, 26
440.2	Atherosclerosis of arteries of the extremities	N	05	130, 131
482.3	Pneumonia due to Streptococcus	Y	04	89, 90, 91
482.8	Pneumonia due to other specified bacteria	Y	04	79, 80, 81
483	Pneumonia due to other specified organism	Y	04	89, 90, 91
524.0	Major anomalies of jaw size	N	03	185, 186, 187
524.1	Anomalies of relationship of jaw to cranial base	N	03	185, 186, 187
596.5	Other functional disorders of bladder	N	11	331, 332, 333
598.8	Other specified disorders of urethra and urinary tract	N	11	331, 332, 333
738.1	Other acquired deformity of head	N	08	256
780.0	Coma and stupor	Y	01	23
788.3	Incontinence of urine	N	11	325, 326, 327

¹ See Table 6a for new diagnosis codes (4- or 5-digits) that will be considered valid by the FY 1993 GROUPE.² Diagnosis code is classified as a "major problem" in these DRGs.

TABLE 6d—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
46.12	Permanent magnetic colostomy	Y	06	148, 149
			17	400, 406, 407
			21	442, 443
			24	486
66.0	Salpingotomy	Y	13	354, 355, 357, 358, 359
69.11	Removal of intraligamentous ectopic pregnancy	Y	13	354, 355, 357, 358, 359
89.49	Artificial pacemaker slew rate check	N	14	375

TABLE 6e—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
079.8	Other specified viral and Chlamydial infections	N	18	421, 422
079.9	Unspecified viral and Chlamydial infection	N	18	421, 422
200.00	Reticulosarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
200.10	Lymphosarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
200.20	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
200.80	Other named variants, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.00	Hodgkin's paraganuloma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.10	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.20	Hodgkin's sarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.40	Lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.50	Nodular sclerosis, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.60	Mixed cellularity, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.70	Lymphocytic depletion, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.90	Hodgkin's disease, unspecified, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.00	Nodular lymphoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.10	Mycosis fungoides, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.20	Sézary's disease, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.30	Malignant histiocytosis, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.40	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.50	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites	Y	17	406, 407, 408, 413, 414

TABLE 6e.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
202.60	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
202.80	Other lymphomas, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.90	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
481	Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia]	Y	04	89, 90, 91
654.20	Previous cesarean delivery, unspecified as to episode of care or not applicable.	N	14	469
654.21	Previous cesarean delivery, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
654.23	Previous cesarean delivery, antepartum condition or complication	N	14	383, 384
665.10	Rupture of uterus during labor, unspecified as to episode of care or not applicable.	Y	14	370, 371, 372, 373, 374, 375
665.11	Rupture of uterus during labor, delivered, with or without mention of antepartum condition.	Y	14	370, 371, 372, 373, 374, 375
665.12	Rupture of uterus during labor, delivered, with mention of postpartum complication.	Y	14	370, 371, 372, 373, 374, 375
665.14	Rupture of uterus during labor, postpartum condition or complication	Y	14	376, 377
692.79	Other dermatitis due to solar radiation	N	09	283, 284
768.4	Fetal distress, unspecified as to time of onset, in liveborn infant	N	15	390
785.2	Undiagnosed cardiac murmurs	N	05	135, 136, 137
V30.00	Single liveborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V30.01	Single liveborn, born in hospital, delivered by cesarean delivery	N	15	391
V31.00	Twin, mate liveborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V31.01	Twin, mate liveborn, born in hospital, delivered by cesarean delivery	N	15	391
V32.00	Twin, mate stillborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V32.01	Twin, mate stillborn, born in hospital, delivered by cesarean delivery	N	15	391
V33.00	Twin, unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V33.01	Twin, unspecified, born in hospital, delivered by cesarean delivery	N	15	391
V34.00	Other multiple, mates all liveborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V34.01	Other multiple, mates all liveborn, born in hospital, delivered by cesarean delivery.	N	15	391
V35.00	Other multiple, mates all stillborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V35.01	Other multiple, mates all stillborn, born in hospital, delivered by cesarean delivery.	N	15	391
V36.00	Other multiple, mates live- and stillborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V36.01	Other multiple, mates live- and stillborn, born in hospital, delivered by cesarean delivery.	N	15	391
V37.00	Other multiple, unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V37.01	Other multiple, unspecified, born in hospital, delivered by cesarean delivery.	N	15	391
V39.00	Liveborn infant, type of birth unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391
V39.01	Liveborn infant, type of birth unspecified, born in hospital, delivered by cesarean delivery.	N	15	391
V73.8	Other specific viral and Chlamydial diseases	N	23	467

TABLE 6f.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
04.01	Excision of acoustic neuroma	Y	01	1, 2, 3
			03	63
46.13	Permanent colostomy	Y	06	148, 149
			17	400, 406, 407
			21	442, 443
			24	488
54.91	Percutaneous abdominal drainage	N		
74.3	Removal of extratubal ectopic pregnancy	Y	14	375
81.59	Revision of joint replacement of lower extremity, not elsewhere classified	Y	08	233, 234
			21	442, 443
			24	488

Table 6g - Additions to the CC Exclusions List

CCs that are added to the list are in Table 6g-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*00321	48289	4830	4838	*01126	48230	48231	48232
32081	4830	4838	*01121	48230	48231	48232	48239
32082	4838	*01113	48230	48231	48232	48239	48281
32089	*01105	48230	48231	48232	48239	48281	48282
*01100	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01151
48281	48282	48283	48289	4830	4838	*01143	48230
48282	48283	48289	4830	4838	*01135	48230	48231
48283	48289	4830	4838	*01130	48230	48231	48232
48289	4830	4838	*01122	48230	48231	48232	48239
4830	4838	*01114	48230	48231	48232	48239	48281
4838	*01106	48230	48231	48232	48239	48281	48282
*01101	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01152
48281	48282	48283	48289	4830	4838	*01144	48230
48282	48283	48289	4830	4838	*01136	48230	48231
48283	48289	4830	4838	*01131	48230	48231	48232
48289	4830	4838	*01123	48230	48231	48232	48239
4830	4838	*01115	48230	48231	48232	48239	48281
4838	*01110	48230	48231	48232	48239	48281	48282
*01102	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01153
48281	48282	48283	48289	4830	4838	*01145	48230
48282	48283	48289	4830	4838	*01140	48230	48231
48283	48289	4830	4838	*01132	48230	48231	48232
48289	4830	4838	*01124	48230	48231	48232	48239
4830	4838	*01116	48230	48231	48232	48239	48281
4838	*01111	48230	48231	48232	48239	48281	48282
*01103	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01154
48281	48282	48283	48289	4830	4838	*01146	48230
48282	48283	48289	4830	4838	*01141	48230	48231
48283	48289	4830	4838	*01133	48230	48231	48232
48289	4830	4838	*01125	48230	48231	48232	48239
4830	4838	*01120	48230	48231	48232	48239	48281
4838	*01112	48230	48231	48232	48239	48281	48282
*01104	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01155
48281	48282	48283	48289	4830	4838	*01150	48230
48282	48283	48289	4830	4838	*01142	48230	48231
48283	48289	4830	4838	*01134	48230	48231	48232

48239	48281	48282	48283	48289	4830	4838	*01206
48281	48282	48283	48289	4830	4838	*01201	48230
48282	48283	48289	4830	4838	*01193	48230	48231
48283	48289	4830	4838	*01185	48230	48231	48232
48289	4830	4838	*01180	48230	48231	48232	48239
4830	4838	*01172	48230	48231	48232	48239	48281
4838	*01164	48230	48231	48232	48239	48281	48282
*01156	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01210
48281	48282	48283	48289	4830	4838	*01202	48230
48282	48283	48289	4830	4838	*01194	48230	48231
48283	48289	4830	4838	*01186	48230	48231	48232
48289	4830	4838	*01181	48230	48231	48232	48239
4830	4838	*01173	48230	48231	48232	48239	48281
4838	*01165	48230	48231	48232	48239	48281	48282
*01160	48230	48231	48232	48239	48281	48282	48283
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48289	4830	4838	*01184	48230	48231	48232	48239
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48289	4830	32082	4838	*01796	03843	*04102	6821
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01782	0388	01145	01306	01396	01660	01770	0381
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01793	6805	01156	01320	01480	01671	01781	03849
01794	6806	01160	01321	01482	01672	01782	0388
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01103	01183	4951	01153	48231	01106	01186	4954
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481	01121	01201	4828	4828	4828	4828	59582
4820	01122	01202	483	483	483	483	59589
4821	01123	01203	*4843	*4954	*5061	*51889	5959
4822	01124	01204	4823	4823	4823	4823	5961
4823	01125	01205	4828	4828	4828	4828	5962
4824	01126	01206	483	483	483	483	5964
4828	01130	01210	*4845	*4955	*5062	*5198	5966
4829	01131	01211	4823	4823	4823	4823	5967
483	01132	01212	4828	4828	4828	4828	5970
4841	01133	01213	483	483	483	483	5981
4843	01134	01214	*4846	*4956	*5063	*5199	5982
4845	01135	01215	4823	4823	4823	4823	5990
4846	01136	01216	4828	4828	4828	4828	5994
4847	01140	0310	483	483	483	483	5996
4848	01141	11505	*4847	*4957	*5064	*5722	5997

*74861	7800	7800	7800	7800	7800	7800	7800
4823	*80023	*80059	*80093	*80129	*80163	*80199	*80333
4828	7800	7800	7800	7800	7800	7800	7800
483	*80024	*80060	*80094	*80130	*80164	*80300	*80334
*7800	7800	7800	7800	7800	7800	7800	7800
430	*80025	*80061	*80095	*80131	*80165	*80301	*80335
431	7800	7800	7800	7800	7800	7800	7800
4320	*80026	*80062	*80096	*80132	*80166	*80302	*80336
4321	7800	7800	7800	7800	7800	7800	7800
436	*80029	*80063	*80099	*80133	*80169	*80303	*80339
7800	7800	7800	7800	7800	7800	7800	7800
*7802	*80030	*80064	*80100	*80134	*80170	*80304	*80340
7800	7800	7800	7800	7800	7800	7800	7800
*7804	*80031	*80065	*80101	*80135	*80171	*80305	*80341
7800	7800	7800	7800	7800	7800	7800	7800
*7809	*80032	*80066	*80102	*80136	*80172	*80306	*80342
7800	7800	7800	7800	7800	7800	7800	7800
*7998	*80033	*80069	*80103	*80139	*80173	*80309	*80343
7800	7800	7800	7800	7800	7800	7800	7800
*80000	*80034	*80070	*80104	*80140	*80174	*80310	*80344
7800	7800	7800	7800	7800	7800	7800	7800
*80001	*80035	*80071	*80105	*80141	*80175	*80311	*80345
7800	7800	7800	7800	7800	7800	7800	7800
*80002	*80036	*80072	*80106	*80142	*80176	*80312	*80346
7800	7800	7800	7800	7800	7800	7800	7800
*80003	*80039	*80073	*80109	*80143	*80179	*80313	*80349
7800	7800	7800	7800	7800	7800	7800	7800
*80004	*80040	*80074	*80110	*80144	*80180	*80314	*80350
7800	7800	7800	7800	7800	7800	7800	7800
*80005	*80041	*80075	*80111	*80145	*80181	*80315	*80351
7800	7800	7800	7800	7800	7800	7800	7800
*80006	*80042	*80076	*80112	*80146	*80182	*80316	*80352
7800	7800	7800	7800	7800	7800	7800	7800
*80009	*80043	*80079	*80113	*80149	*80183	*80319	*80353
7800	7800	7800	7800	7800	7800	7800	7800
*80010	*80044	*80080	*80114	*80150	*80184	*80320	*80354
7800	7800	7800	7800	7800	7800	7800	7800
*80011	*80045	*80081	*80115	*80151	*80185	*80321	*80355
7800	7800	7800	7800	7800	7800	7800	7800
*80012	*80046	*80082	*80116	*80152	*80186	*80322	*80356
7800	7800	7800	7800	7800	7800	7800	7800
*80013	*80049	*80083	*80119	*80153	*80189	*80323	*80359
7800	7800	7800	7800	7800	7800	7800	7800
*80014	*80050	*80084	*80120	*80154	*80190	*80324	*80360
7800	7800	7800	7800	7800	7800	7800	7800
*80015	*80051	*80085	*80121	*80155	*80191	*80325	*80361
7800	7800	7800	7800	7800	7800	7800	7800
*80016	*80052	*80086	*80122	*80156	*80192	*80326	*80362
7800	7800	7800	7800	7800	7800	7800	7800
*80019	*80053	*80089	*80123	*80159	*80193	*80329	*80363
7800	7800	7800	7800	7800	7800	7800	7800
*80020	*80054	*80090	*80124	*80160	*80194	*80330	*80364
7800	7800	7800	7800	7800	7800	7800	7800
*80021	*80055	*80091	*80125	*80161	*80195	*80331	*80365
7800	7800	7800	7800	7800	7800	7800	7800
*80022	*80056	*80092	*80126	*80162	*80196	*80332	*80366

7800	7800	7800	7800	7800	7800	7800	7800
*80369	*80403	*80439	*80473	*85101	*85135	*85171	*85205
7800	7800	7800	7800	7800	7800	7800	7800
*80370	*80404	*80440	*80474	*85102	*85136	*85172	*85206
7800	7800	7800	7800	7800	7800	7800	7800
*80371	*80405	*80441	*80475	*85103	*85139	*85173	*85209
7800	7800	7800	7800	7800	7800	7800	7800
*80372	*80406	*80442	*80476	*85104	*85140	*85174	*85210
7800	7800	7800	7800	7800	7800	7800	7800
*80373	*80409	*80443	*80479	*85105	*85141	*85175	*85211
7800	7800	7800	7800	7800	7800	7800	7800
*80374	*80410	*80444	*80480	*85106	*85142	*85176	*85212
7800	7800	7800	7800	7800	7800	7800	7800
*80375	*80411	*80445	*80481	*85109	*85143	*85179	*85213
7800	7800	7800	7800	7800	7800	7800	7800
*80376	*80412	*80446	*80482	*85110	*85144	*85180	*85214
7800	7800	7800	7800	7800	7800	7800	7800
*80379	*80413	*80449	*80483	*85111	*85145	*85181	*85215
7800	7800	7800	7800	7800	7800	7800	7800
*80380	*80414	*80450	*80484	*85112	*85146	*85182	*85216
7800	7800	7800	7800	7800	7800	7800	7800
*80381	*80415	*80451	*80485	*85113	*85149	*85183	*85219
7800	7800	7800	7800	7800	7800	7800	7800
*80382	*80416	*80452	*80486	*85114	*85150	*85184	*85221
7800	7800	7800	7800	7800	7800	7800	7800
*80383	*80419	*80453	*80489	*85115	*85151	*85185	*85222
7800	7800	7800	7800	7800	7800	7800	7800
*80384	*80420	*80454	*80490	*85116	*85152	*85186	*85223
7800	7800	7800	7800	7800	7800	7800	7800
*80385	*80421	*80455	*80491	*85119	*85153	*85189	*85224
7800	7800	7800	7800	7800	7800	7800	7800
*80386	*80422	*80456	*80492	*85120	*85154	*85190	*85225
7800	7800	7800	7800	7800	7800	7800	7800
*80389	*80423	*80459	*80493	*85121	*85155	*85191	*85226
7800	7800	7800	7800	7800	7800	7800	7800
*80390	*80424	*80460	*80494	*85122	*85156	*85192	*85229
7800	7800	7800	7800	7800	7800	7800	7800
*80391	*80425	*80461	*80495	*85123	*85159	*85193	*85230
7800	7800	7800	7800	7800	7800	7800	7800
*80392	*80426	*80462	*80496	*85124	*85160	*85194	*85231
7800	7800	7800	7800	7800	7800	7800	7800
*80393	*80429	*80463	*8500	*85125	*85161	*85195	*85232
7800	7800	7800	7800	7800	7800	7800	7800
*80394	*80430	*80464	*8501	*85126	*85162	*85196	*85233
7800	7800	7800	7800	7800	7800	7800	7800
*80395	*80431	*80465	*8502	*85129	*85163	*85199	*85234
7800	7800	7800	7800	7800	7800	7800	7800
*80396	*80432	*80466	*8503	*85130	*85164	*85200	*85235
7800	7800	7800	7800	7800	7800	7800	7800
*80399	*80433	*80469	*8504	*85131	*85165	*85201	*85236
7800	7800	7800	7800	7800	7800	7800	7800
*80400	*80434	*80470	*8505	*85132	*85166	*85202	*85239
7800	7800	7800	7800	7800	7800	7800	7800
*80401	*80435	*80471	*8509	*85133	*85169	*85203	*85240
7800	7800	7800	7800	7800	7800	7800	7800
*80402	*80436	*80472	*85100	*85134	*85170	*85204	*85241

7800	7800
*85242	*85316
7800	7800
*85243	*85319
7800	7800
*85244	*85400
7800	7800
*85245	*85401
7800	7800
*85246	*85402
7800	7800
*85249	*85403
7800	7800
*85250	*85404
7800	7800
*85251	*85405
7800	7800
*85252	*85406
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*85253	*85409
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*85254	*85410
7800	7800
*85255	*85411
7800	7800
*85256	*85412
7800	7800
*85259	*85413
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*85300	*85414
7800	7800
*85301	*85415
7800	7800
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*85303	*85419
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*85304	
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*85305	
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*85314	
7800	
*85315	

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28876	15.9617	4	7	11	19	32
002	6031	15.1069	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5300	13.0400	3	5	9	16	27
005	53888	6.7782	2	3	5	8	13
006	888	3.2857	1	1	2	3	7
007	5961	22.0785	2	6	11	23	47
008	2772	4.6032	1	1	3	6	10
009	1731	10.3039	2	4	7	12	21
010	20406	10.9344	2	4	7	14	22
011	3565	6.3719	1	2	4	8	13
012	21663	10.6732	2	4	7	12	19
013	5723	8.5598	3	4	7	10	15
014	342315	10.0711	3	4	7	12	19
015	135323	5.4583	2	3	4	6	10
016	11124	9.3788	3	4	7	11	18
017	2966	5.8736	2	3	4	7	10
018	13951	8.0095	2	4	6	9	15
019	6986	5.4705	1	2	4	7	10
020	7578	12.6498	3	5	9	16	25
021	1032	9.6909	3	4	7	12	19
022	9831	5.5487	2	3	4	7	10
023	3143	6.2685	1	2	4	7	12
024	54473	7.3996	2	3	5	9	14
025	22879	4.4291	1	2	3	5	8
026	61	5.9344	1	2	3	5	8
027	2808	8.2942	1	2	3	5	8
028	8249	9.5305	2	3	4	7	10
029	3690	4.8705	1	2	3	5	8
030	2	1.0000	1	1	1	1	1
031	3757	7.0186	2	2	3	4	7
032	2713	3.6922	1	2	3	4	7
034	13703	8.9718	2	3	6	10	17
035	3837	5.2434	1	2	3	5	8
036	20529	2.3437	1	1	2	3	4
037	2746	4.6555	1	1	2	3	5
038	784	2.8426	1	1	1	2	3
039	9719	1.9414	1	1	1	2	3
040	3422	3.4278	1	1	2	3	4
042	20598	2.5786	1	1	2	3	4
043	207	5.5266	1	2	4	7	10
044	1996	6.2856	2	4	5	8	12
045	2641	4.4623	1	2	4	7	10
046	2904	6.3402	1	2	4	7	10
047	1891	4.4093	1	1	2	3	4
048	2	7.0000	5	5	9	9	9
049	2965	7.5400	2	3	5	8	12
050	4928	2.6331	1	1	2	3	4
051	534	2.8614	1	1	2	3	4
052	175	3.1886	1	1	2	3	4
053	6507	3.4372	1	1	2	3	4

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3659	2.7349	1	1	1	2	6
056	1151	2.7958	1	1	2	3	6
057	710	5.3620	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	185	2.1568	1	1	1	2	4
060	1	18.0000	18	18	18	18	18
061	385	5.0026	1	1	2	6	12
063	4945	5.6977	1	2	4	7	12
064	4372	8.9318	1	2	6	11	20
065	32587	4.1850	1	2	3	5	8
066	7860	4.3584	1	2	3	5	8
067	437	5.2014	2	3	4	6	9
068	11729	6.0495	2	3	5	7	11
069	3772	4.2858	2	2	4	5	8
070	18	4.3889	1	2	4	5	8
071	136	5.1176	2	3	4	5	8
072	685	5.7460	2	3	4	6	10
073	6685	6.0432	1	2	3	6	9
074	2	11.0000	9	9	13	13	12
075	32193	13.7943	6	8	10	13	13
076	40220	14.8394	4	7	11	18	26
077	3502	6.5580	1	2	5	9	14
078	26963	10.0607	4	7	9	12	16
079	140699	11.8842	4	6	9	14	22
080	9304	7.9451	3	4	7	10	14
081	1	7.0000	7	7	7	7	7
082	70711	9.5833	2	4	7	12	19
083	7420	8.1515	2	4	6	10	15
084	1879	4.4050	1	2	3	6	8
085	17755	9.0945	2	4	7	11	17
086	1757	5.3199	1	2	4	7	10
087	61415	8.1182	2	4	6	10	15
088	166636	7.3928	3	4	6	9	13
089	380530	8.7583	3	5	7	11	15
090	46157	6.2364	3	4	5	8	10
091	48	6.1042	2	3	5	7	11
092	9085	8.7428	3	4	5	7	11
093	1504	6.0632	2	3	5	8	11
094	9730	9.5251	3	4	7	11	18
095	1324	6.1284	2	3	4	7	10
096	181510	7.1153	3	4	6	8	12
097	32577	5.1442	2	3	4	6	9
098	18	6.2778	2	3	4	6	10
099	31096	5.1861	1	2	4	6	10
100	11482	3.1253	1	2	4	6	10
101	19157	6.8025	2	3	4	6	10
102	3754	4.3207	1	2	3	5	8
103	282	33.8262	10	14	21	40	68
104	17814	20.3496	9	12	17	25	35
105	16203	14.4956	7	9	11	18	25
106	76162	15.2542	8	10	13	17	24

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
107	52857	11.7523	7	8	9	13	18
108	8959	15.2274	7	9	12	18	28
110	51947	13.5024	3	8	11	16	25
111	6304	8.4123	3	6	8	10	13
112	131484	6.0934	2	3	5	8	12
113	37250	19.0177	6	8	14	23	37
114	8226	12.4919	3	5	9	15	24
115	8518	13.9283	5	8	11	17	24
116	65949	7.2686	2	3	6	9	14
117	3402	5.5091	2	3	3	7	12
118	8487	3.9126	1	1	2	4	8
119	3237	6.3031	1	2	3	7	15
120	35546	12.2367	2	3	3	15	27
121	146199	9.6359	4	6	8	11	16
122	100359	6.8565	2	4	7	9	11
123	56218	5.3458	1	1	3	7	13
124	125726	5.7739	1	1	2	7	11
125	89536	3.1482	1	1	2	4	7
126	4302	20.4328	5	10	16	29	41
127	612827	7.7476	2	4	6	9	14
128	23541	8.4050	4	5	7	10	13
129	6269	4.7437	1	1	1	6	12
130	71880	8.1132	2	4	7	10	14
131	26526	5.9725	1	3	6	8	10
132	12394	5.5501	1	2	4	7	11
133	4077	3.9146	1	2	3	5	7
134	29162	4.9837	2	2	4	6	9
135	6400	6.5938	2	3	5	8	13
136	1424	4.2507	1	2	3	5	7
138	188352	5.8759	2	3	4	7	11
139	72186	3.6766	1	2	3	5	7
140	346480	4.4712	2	2	3	5	8
141	77799	5.7258	2	3	4	7	10
142	37177	3.9232	1	2	3	5	7
143	117399	3.3738	1	2	3	5	7
144	56530	7.0916	1	2	3	5	6
145	8425	4.1858	1	2	3	5	8
146	7640	13.8241	7	9	11	15	23
147	1590	8.9233	5	7	9	11	13
148	143851	15.9248	7	9	12	19	28
149	18122	9.0774	6	8	11	17	25
150	21960	13.9135	5	7	9	12	18
151	4781	7.7473	3	4	7	10	13
152	4605	10.6725	5	7	9	12	18
153	2059	7.0515	4	5	7	8	10
154	37694	18.0724	7	9	14	22	34
155	4202	8.5626	4	5	7	10	14
157	13356	6.5860	2	3	4	8	13
158	9999	3.0529	1	1	2	4	6
159	16539	6.3772	2	3	4	8	12
160	12946	3.3294	1	2	3	4	6

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
161	24227	4.6378	1	2	3	6	10
162	21251	2.2036	1	1	2	3	4
163	13	2.8923	1	1	2	4	5
164	4685	11.4055	5	7	9	13	19
165	1819	6.9940	3	5	7	9	11
166	2982	7.1596	3	4	6	9	13
167	2188	4.1185	2	3	4	5	7
168	1871	5.7691	1	2	3	7	12
169	1391	2.8248	1	1	2	3	6
170	12992	15.8273	3	7	11	20	31
171	1463	6.8578	1	3	5	9	13
172	31475	10.4531	2	4	7	13	22
173	3266	5.2655	1	2	4	7	11
174	168078	6.9517	2	4	5	8	13
175	22521	4.3582	2	3	4	5	7
176	13120	7.7104	2	4	6	9	14
177	15059	6.2747	2	3	5	7	11
178	6479	4.4373	2	3	4	5	8
179	8803	9.5372	3	4	7	11	18
180	70546	7.6470	2	4	6	9	14
181	22180	4.5757	2	3	4	6	8
182	261192	6.2600	2	3	5	7	11
183	77885	4.1977	1	2	3	5	8
184	59	4.0508	1	2	3	4	7
185	3939	6.2591	1	3	5	8	12
186	1	4.0000	4	4	4	4	4
187	1050	3.8629	1	1	2	3	4
188	50649	7.4105	2	3	4	5	8
189	9116	3.8873	1	1	3	5	15
190	99	5.3131	2	3	4	5	8
191	10256	20.0999	7	10	15	24	40
192	965	9.5440	3	6	8	12	16
193	12818	16.6354	7	9	14	20	29
194	1427	9.6797	3	6	9	12	17
195	17622	12.3429	6	7	10	14	20
196	1802	8.0733	4	5	7	10	13
197	78222	8.5152	2	4	7	11	16
198	49186	3.6220	1	1	3	5	7
199	2886	14.4016	4	7	11	18	28
200	1957	13.6811	2	5	10	18	28
201	3042	14.3859	3	6	10	18	30
202	18194	9.7128	2	4	7	12	19
203	29827	9.7880	2	4	7	12	20
204	39939	8.0722	3	4	6	9	15
205	21234	9.1487	2	4	7	11	18
206	2450	5.0184	1	2	4	7	13
207	38205	7.0373	2	3	5	9	17
208	14164	4.0378	1	2	3	5	7
209	271606	10.5789	6	7	9	12	16
210	118940	13.0684	6	8	10	14	21
211	29021	9.4534	5	6	8	11	14

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
212	18	6.1111	2	2	3	7	9
213	5859	13.0282	3	6	9	16	25
214	42479	10.3023	4	5	8	12	19
215	38652	6.0877	3	4	5	7	10
216	7180	14.5876	3	6	11	18	29
217	17145	21.5360	4	8	14	27	46
218	18844	9.1075	3	4	7	11	17
219	18074	5.1644	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4936	10.7784	2	4	8	13	21
222	5308	5.2472	1	2	4	7	10
223	16064	4.0505	1	2	3	4	7
224	8886	2.9099	1	2	2	3	5
225	10186	5.2852	1	2	3	6	12
226	5572	9.0720	2	3	6	11	20
227	6542	3.8658	1	2	3	4	7
228	4411	3.7150	1	1	2	4	8
229	2541	2.6564	1	1	2	3	5
230	3279	6.4535	1	2	4	7	13
231	10405	6.5790	1	2	4	7	15
232	809	6.6897	1	2	3	7	17
233	5329	11.7467	3	5	9	15	23
234	3072	5.3665	1	2	4	7	11
235	6401	11.4805	2	4	7	12	24
236	38084	8.9773	2	4	7	10	17
237	1693	5.8328	2	3	4	7	10
238	6472	13.9322	4	6	10	17	28
239	60286	10.0598	3	5	10	12	19
240	11175	9.5085	3	4	7	11	18
241	4000	5.6287	2	3	4	7	11
242	2544	10.5491	3	5	8	13	22
243	106101	6.8511	2	3	5	9	13
244	11219	7.2646	2	3	5	9	14
245	5730	5.5091	1	2	4	6	10
246	1753	5.4780	1	2	3	6	10
247	9961	5.1535	1	2	3	6	10
248	6331	6.2402	2	3	4	7	12
249	8552	6.4259	1	2	3	6	13
250	3461	6.8050	2	3	4	8	13
251	3274	3.6130	1	1	2	4	7
253	17409	8.1683	2	3	6	9	16
254	12343	4.7343	1	2	3	6	9
255	2	2.5000	1	1	2	4	4
256	9411	5.4601	1	2	3	6	11
257	28803	5.1188	2	3	4	6	9
258	26586	3.6258	2	2	3	4	6
259	4071	5.9580	1	2	3	6	13
260	4963	2.5350	1	1	2	3	4
261	3080	2.8042	1	1	2	3	5
262	1296	3.5517	1	1	2	3	7
263	29564	20.5709	5	8	14	24	41

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
264	4234	11.3791	3	5	8	14	23
265	4999	9.8200	2	3	6	11	21
266	4190	4.4174	1	2	3	5	9
267	379	4.8021	1	1	3	5	11
268	1482	5.0628	1	1	2	5	9
269	11065	12.2933	2	4	9	15	25
270	5144	4.0072	1	2	3	5	8
271	20052	11.6591	3	5	8	13	21
272	6944	9.4241	3	5	7	11	18
273	2223	6.8277	2	3	5	8	14
274	3099	10.9935	2	4	7	13	21
275	383	5.6789	1	1	3	5	9
276	877	5.6328	1	2	4	7	11
277	72052	8.4759	3	5	7	10	15
278	26250	6.1446	3	4	5	7	10
279	6	7.0000	2	3	4	11	11
280	13349	6.8287	2	3	5	8	13
281	7419	4.1867	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5928	7.2763	2	3	5	8	14
284	2390	5.0753	1	2	4	6	9
285	4656	21.4021	5	9	15	25	41
286	1753	11.3440	5	6	8	13	22
287	6675	18.9768	5	7	12	21	39
288	533	10.1576	3	4	6	10	21
289	4013	5.6845	2	2	3	5	12
290	9686	3.4577	1	2	2	4	6
291	146	2.1027	1	1	2	2	4
292	5120	17.8982	4	7	13	22	35
293	496	7.4839	1	3	6	10	15
294	90766	7.2914	3	4	6	8	13
295	3379	5.8387	2	3	4	7	11
296	215338	8.3968	2	4	6	10	16
297	44861	5.2013	2	3	4	6	9
298	69	4.4638	1	2	2	5	7
299	888	6.6678	1	3	5	8	14
300	12045	9.3865	3	4	7	11	18
301	2085	5.3050	1	2	4	7	10
302	7144	15.9681	7	9	13	19	28
303	17590	13.3629	6	8	10	15	23
304	14273	13.5524	4	6	10	16	26
305	3538	6.4002	2	3	5	8	12
306	12338	8.8517	3	4	6	11	17
307	4245	4.5246	2	3	4	5	8
308	10437	9.0834	2	3	6	11	19
309	4429	3.9600	1	2	3	5	8
310	35678	5.6214	1	2	4	7	11
311	19461	2.6887	1	1	2	3	5
312	3139	5.5027	1	2	4	7	11
313	1844	2.7533	1	1	2	3	5
314	1	8.0000	8	8	8	8	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
315	27894	12.3810	1	3	7	15	27
316	49895	9.1767	2	4	7	12	19
317	745	4.1195	1	2	3	4	8
318	6697	9.0769	2	3	6	11	19
319	839	3.9774	1	1	2	5	8
320	165178	8.4285	3	4	6	10	15
321	29299	5.8938	2	3	5	7	10
322	53	5.6038	2	3	5	7	10
323	20914	4.2820	1	2	3	5	9
324	13699	2.5722	1	1	2	3	5
325	9767	5.7981	2	3	4	7	11
326	3603	3.5795	1	2	3	4	7
327	10	6.5000	1	2	5	8	10
328	1298	4.9581	1	1	4	6	9
329	338	2.8787	1	1	2	4	5
331	30171	7.5097	2	3	6	9	15
332	5910	4.4795	1	2	3	5	9
333	339	7.6254	2	3	5	10	16
334	22733	9.1258	5	6	8	10	14
335	10704	7.2682	5	6	7	8	10
336	107269	5.8199	3	3	4	7	10
337	89282	3.8213	2	3	3	4	6
338	7501	5.3325	1	1	2	3	13
339	3288	4.6946	1	1	2	3	11
340	3	4.6667	3	3	4	5	7
341	13025	4.4253	1	2	3	5	8
342	416	3.8341	1	1	2	3	9
343	2	2.0000	1	1	2	3	3
344	4869	5.3828	1	2	3	6	10
345	2562	4.8989	1	2	3	5	10
346	7815	8.6271	2	3	6	10	17
347	925	4.4108	1	1	3	5	9
348	4360	5.7681	1	2	4	7	11
349	1641	3.0494	1	1	2	4	6
350	8153	5.8803	2	3	3	7	10
352	787	4.8475	1	2	3	6	21
353	2326	11.4596	5	6	8	14	21
354	9569	8.2302	4	5	6	9	14
355	6048	4.9854	3	4	5	6	7
356	31936	4.3107	2	3	4	5	7
357	6917	12.5038	5	7	10	15	23
358	23628	6.5656	3	4	5	7	11
359	27186	4.4800	3	4	4	5	6
360	9695	5.2309	2	3	4	5	9
361	448	5.5670	1	2	3	6	14
363	5796	4.3171	1	2	3	4	8
364	2694	4.1771	1	1	3	5	8
365	3201	10.7688	3	4	7	13	23
366	4975	10.1785	2	3	7	13	22
367	817	3.9584	1	1	3	4	8
368	1515	7.5129	2	4	6	9	14

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPEL V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2542	4.547	1	2	3	6	9
370	683	7.040	3	4	5	7	11
371	764	4.419	3	3	4	5	6
372	443	3.731	1	2	3	4	6
373	2715	2.594	1	2	2	3	3
374	75	4.027	2	2	2	3	6
375	7	14.714	1	2	2	7	14
376	160	2.906	1	1	2	3	6
377	27	5.111	1	2	2	7	10
378	144	3.632	2	2	4	4	6
379	329	2.960	1	1	2	3	6
380	72	2.792	1	1	1	3	6
381	245	2.482	1	1	1	3	4
382	50	1.433	1	1	1	2	2
383	900	4.437	1	2	3	5	9
384	104	2.654	1	1	2	3	6
385	5	3.000	1	1	3	4	6
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
388	8	8.375	1	4	7	9	11
389	18	6.056	1	4	7	11	13
390	2500	14.038	5	7	10	18	27
392	1992	10.334	1	2	6	12	22
394	72540	6.472	2	3	5	8	13
395	13	3.154	1	1	2	2	5
396	12786	7.490	2	3	5	9	15
397	14721	8.382	3	4	6	10	15
398	1662	5.261	1	2	5	7	10
399	8125	13.401	3	4	6	17	28
400	6816	15.097	3	5	9	19	31
401	2346	5.159	1	2	3	7	11
402	28354	12.006	2	2	8	15	25
403	5255	5.683	1	2	4	7	12
404	5	2.000	1	1	2	3	3
405	3737	15.477	4	7	11	19	31
406	958	6.558	2	3	5	8	12
407	4841	8.490	2	3	5	10	20
408	7660	9.110	1	2	5	11	21
409	124349	3.621	1	2	3	5	6
410	162	3.272	1	1	2	4	7
411	157	2.892	1	1	2	4	6
412	9700	10.734	2	4	8	14	22
413	1716	6.115	1	2	4	8	13
414	29926	20.640	5	9	15	25	41
415	138291	10.414	2	3	5	13	19
416	47	5.532	2	3	5	7	8
417	14577	8.311	3	4	7	10	15
418	17412	7.497	2	4	6	9	14
419	3780	5.416	2	3	4	7	10
420	12412	5.645	2	3	4	7	10
421	109	6.156	2	3	5	7	12
422							

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
423	7323	11.226	3	5	8	13	22
424	2818	23.715	3	8	16	28	47
425	18133	6.508	2	3	4	8	13
426	6147	7.331	2	3	5	9	15
427	2046	7.858	1	3	5	9	16
428	1150	10.689	2	3	6	13	24
429	31113	12.334	3	4	7	13	23
430	57475	12.437	3	5	9	16	25
431	250	11.300	1	3	5	9	14
432	548	7.708	1	2	4	8	15
433	6008	4.534	1	1	3	5	11
434	18337	7.918	2	3	5	9	15
435	12935	6.364	2	3	5	9	13
436	2504	17.861	5	10	19	25	28
437	10883	16.706	6	10	15	23	28
438	971	9.550	1	3	6	12	21
440	4736	13.224	2	4	8	16	28
441	872	3.688	1	1	2	4	8
442	11761	9.987	1	3	6	12	21
443	6002	3.737	1	1	2	5	8
444	4028	7.426	2	3	5	9	13
445	2264	4.339	1	2	3	5	8
447	3187	3.543	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29594	6.013	1	2	4	7	12
450	7607	3.304	1	1	2	4	7
451	7	147.571	1	3	5	10	13
452	18057	6.266	1	2	4	7	11
453	5986	3.560	1	2	4	7	13
454	4165	7.084	1	2	4	7	14
455	1149	3.269	1	1	2	4	6
456	182	8.242	1	2	5	10	21
457	127	8.835	1	2	5	10	18
458	1650	22.930	5	10	17	30	45
459	585	14.899	3	6	11	18	30
460	2421	9.185	2	4	7	12	19
461	5377	5.533	1	1	2	5	13
462	6756	17.934	5	8	15	23	33
463	8499	6.760	2	3	5	9	13
464	2995	4.124	1	2	3	5	8
465	448	3.364	1	1	2	3	6
466	3722	5.015	1	1	2	3	10
467	3626	6.329	1	1	2	3	10
468	63537	19.076	4	8	14	23	37
471	7812	14.127	7	9	14	16	23
472	184	29.788	1	8	24	43	63
473	8381	17.072	2	8	10	26	41
475	75734	14.078	2	4	11	18	28
476	10885	17.193	6	6	14	20	29
477	37365	10.590	1	3	7	13	22
478	105150	10.267	2	4	7	13	21

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 08/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28876	15.9617	4	7	11	19	32
002	6031	15.1069	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5300	13.0400	3	5	9	16	27
005	53888	6.7762	2	3	5	8	13
006	868	3.2857	1	1	2	3	7
007	5961	22.0765	2	6	11	23	47
008	2772	4.6032	1	1	3	6	10
009	1731	10.3039	2	4	7	12	21
010	20406	10.9344	2	4	7	14	22
011	3565	6.3719	1	2	4	8	13
012	21663	10.6732	2	4	7	12	19
013	5723	8.5598	3	4	7	10	15
014	342315	10.0711	3	4	7	12	19
015	135323	5.4583	2	3	4	6	10
016	11124	9.3788	3	4	7	11	18
017	2966	5.8736	2	3	4	7	10
018	13951	8.0095	2	4	6	9	15
019	6986	5.4705	1	2	4	7	10
020	7578	12.6498	3	5	9	16	25
021	1032	9.6909	3	4	7	12	19
022	9831	5.5487	2	3	4	7	10
023	3143	6.2685	1	2	4	7	12
024	54473	7.3996	2	3	5	9	14
025	22879	4.4291	1	2	3	5	8
026	61	5.9344	1	2	3	5	8
027	2808	8.2942	1	2	3	5	8
028	8249	9.5305	2	3	4	7	10
029	3690	4.8705	1	2	3	5	8
030	2	1.0000	1	1	1	1	1
031	3757	7.0186	2	2	4	8	13
032	2713	3.6922	1	2	3	4	7
034	13703	8.9718	2	3	6	10	17
035	3837	5.2434	1	2	3	5	8
036	20529	2.3437	1	1	2	3	4
037	2746	4.6555	1	1	2	3	5
038	784	2.9426	1	1	2	3	4
039	9719	1.9414	1	1	2	3	4
040	3422	3.4278	1	1	2	3	4
042	20598	2.5786	1	1	2	3	4
043	207	5.5266	1	2	3	5	8
044	1996	6.2856	2	4	5	7	10
045	2641	4.4623	1	2	3	5	8
046	2904	6.3402	1	2	3	5	8
047	1891	4.4093	1	1	2	3	4
048	2	7.0000	5	5	9	15	25
049	2965	7.5400	2	3	5	9	15
050	4906	2.6229	1	1	2	3	4
051	534	2.8614	1	1	2	3	4
052	175	3.1886	1	1	2	3	4
053	6529	3.4422	1	1	2	3	4

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 08/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3659	2.7349	1	1	1	2	6
056	1151	2.7858	1	1	2	3	6
057	710	5.3620	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	185	2.1568	1	1	1	2	4
060	1	18.0000	18	18	18	18	18
061	385	5.0026	1	1	2	6	12
063	4945	5.6977	1	2	4	7	12
064	4372	8.9318	1	2	6	11	20
065	32587	4.1850	1	2	3	5	8
066	7860	4.3564	1	2	3	5	8
067	437	5.2014	2	3	4	7	11
068	11729	6.0495	2	3	5	7	11
069	3772	4.2858	2	2	4	5	8
070	18	4.3889	2	2	4	5	8
071	136	5.1176	2	3	4	5	8
072	685	5.7460	1	3	4	5	8
073	6685	6.0432	1	2	3	6	10
074	2	11.0000	1	2	3	7	12
075	32193	13.7943	9	9	13	13	13
076	40220	14.8394	6	8	10	18	26
077	3502	6.5580	4	7	11	18	28
078	26963	10.0607	1	2	5	9	14
079	140699	11.8842	4	7	9	12	18
080	9304	7.8451	3	6	9	14	22
081	1	7.0000	3	4	7	10	14
082	70711	9.5833	2	7	7	7	7
083	7420	8.1515	2	4	6	12	19
084	1879	4.4050	2	4	6	10	15
085	17755	9.0945	1	2	3	6	8
086	1757	5.3199	2	4	7	11	17
087	61415	8.1182	1	2	4	7	10
088	166335	7.3926	2	4	6	10	15
089	380530	8.7583	3	5	7	11	15
090	46157	6.2384	3	4	5	8	10
091	48	6.1042	3	4	5	7	11
092	9095	8.7428	2	3	5	7	11
093	1504	6.0632	2	3	5	8	11
094	9730	9.5251	2	3	5	11	18
095	1324	6.1284	3	4	7	11	18
096	181510	7.1153	2	3	6	8	12
097	32577	5.1442	2	3	4	6	9
098	18	6.2778	2	3	4	6	10
099	31096	5.1861	2	2	4	6	10
100	11482	3.1253	1	2	4	4	6
101	19157	6.8025	1	2	4	4	6
102	3754	4.3207	2	2	5	8	13
103	282	33.8262	10	14	21	40	68
104	17814	20.3496	9	12	17	25	35
105	16203	14.4966	7	9	11	16	25
106	76162	15.2542	8	10	13	17	24

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
107	52857	11.7523	7	8	9	13	18
108	8959	15.2274	7	9	12	18	28
110	51947	13.5024	3	8	11	16	25
111	6304	8.4123	3	6	8	10	13
112	131196	6.0898	2	3	5	8	12
113	37297	19.0379	6	8	14	23	37
114	8229	12.4901	3	5	9	15	24
115	8512	13.9016	5	8	11	17	24
116	67194	7.2077	2	3	5	9	14
117	3381	5.5061	1	2	3	7	12
118	8483	3.9088	1	1	2	4	8
119	3237	6.3031	1	2	3	7	15
120	34573	12.4687	2	3	8	16	27
121	146199	9.6359	4	6	8	11	16
122	100359	6.8565	2	4	7	9	11
123	56218	5.3458	1	1	3	7	13
124	125726	5.7739	1	2	5	7	11
125	89536	3.1482	1	1	2	4	7
126	4302	20.4328	5	10	16	29	41
127	612827	7.7476	2	4	6	9	14
128	23541	8.4050	4	5	7	10	13
129	6269	4.7437	1	1	1	6	12
130	71880	8.1132	2	4	7	14	14
131	26526	5.9725	1	3	6	8	10
132	12394	5.5501	1	2	4	7	11
133	4077	3.9146	1	2	3	5	7
134	29162	4.9837	2	2	4	6	9
135	6400	6.5938	2	3	5	8	13
136	1424	4.2507	1	2	3	5	7
138	188352	5.8759	1	3	4	7	11
139	72186	3.6766	1	2	3	5	7
140	346480	4.4712	2	2	4	5	8
141	77799	5.7258	2	3	4	7	10
142	37177	3.9232	1	2	3	5	7
143	117399	3.3738	1	2	3	5	6
144	56530	7.0916	1	3	5	9	14
145	8425	4.1858	1	2	3	5	8
146	7640	13.8241	7	9	11	15	23
147	1590	8.9233	5	7	9	11	13
148	143851	15.9248	7	9	12	19	28
149	18122	9.0774	6	7	10	13	13
150	21960	13.9135	5	8	11	17	25
151	4781	7.7473	3	4	7	10	13
152	4605	10.6725	5	7	9	12	18
153	2059	7.0515	4	5	7	8	10
154	37694	18.0724	7	9	14	22	34
155	4202	8.5626	4	5	7	10	14
157	13356	6.5860	2	3	4	8	13
158	9999	3.0529	1	1	2	4	6
159	16539	6.3772	2	3	5	8	12
160	12946	3.3294	1	2	3	4	6

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
161	24237	4.6376	1	2	3	6	10
162	21251	2.2036	1	1	2	3	4
163	13	2.6923	1	1	2	4	5
164	4885	11.4055	5	7	9	13	19
165	1819	6.9940	3	5	7	9	11
166	2982	7.1596	3	4	6	9	13
167	2188	4.1165	2	3	4	5	7
168	1871	5.7691	1	2	3	3	6
169	1391	2.8246	1	1	2	3	7
170	12992	15.9273	3	7	11	20	31
171	1463	6.8578	1	3	5	9	13
172	31475	10.4531	2	4	7	13	22
173	3266	5.2655	1	2	4	7	11
174	168078	6.9517	2	3	5	8	13
175	22521	4.3582	2	3	4	5	7
176	13120	7.7104	2	4	6	9	14
177	15059	6.2747	2	3	5	7	11
178	6479	4.4373	2	3	4	5	8
179	8803	9.5372	3	4	7	11	18
180	70546	7.6470	2	4	6	9	14
181	22180	4.5757	2	3	5	7	11
182	261192	6.2600	2	3	5	7	11
183	77885	4.1977	1	2	3	4	8
184	59	4.0508	1	2	3	4	7
185	3999	6.2591	1	2	3	4	7
186	1	4.0000	1	2	3	4	7
187	1050	3.8629	1	1	2	3	4
188	50649	7.4105	2	3	5	8	12
189	9116	3.8873	1	2	3	4	7
190	99	5.3131	2	3	5	9	15
191	10256	20.0999	7	10	15	24	38
192	965	9.5440	3	6	10	15	24
193	12618	16.6354	7	9	14	20	29
194	1427	9.6797	3	6	10	14	20
195	17622	12.3429	6	7	10	14	20
196	1802	8.0733	4	5	7	10	13
197	78222	8.5152	2	4	7	11	16
198	49186	3.6220	1	1	3	5	7
199	2886	14.4016	4	7	11	18	28
200	1957	13.6811	2	5	10	18	28
201	3042	14.3859	3	6	10	18	30
202	18194	9.7128	2	4	7	12	19
203	29827	9.7680	2	4	7	12	20
204	39939	8.0722	2	4	6	9	15
205	21234	9.1487	2	4	7	11	18
206	2450	5.0184	1	2	4	7	10
207	38205	7.0373	2	3	5	9	13
208	14164	4.0379	1	2	3	5	7
209	271606	10.5789	6	7	9	12	16
210	118940	13.0684	6	8	10	14	21
211	29021	9.4534	5	6	8	11	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
212	18	6.1111	2	2	3	7	9
213	5859	13.0282	3	6	9	16	25
214	42478	10.3023	4	5	8	12	19
215	38652	6.0877	3	4	5	7	10
216	7180	14.5876	3	6	11	18	29
217	17145	21.5360	4	8	14	27	48
218	18844	9.1075	3	4	7	11	17
219	18074	5.1644	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4936	10.7784	2	4	8	13	21
222	5308	5.2472	1	2	4	7	10
223	16039	4.0491	1	2	3	4	7
224	8888	2.9089	1	2	2	3	5
225	10360	5.2777	1	2	3	6	12
226	5572	9.0720	2	3	6	11	20
227	6542	3.8658	1	2	3	4	7
228	4272	3.6987	1	1	2	4	8
229	2541	2.6564	1	1	2	3	5
230	3279	6.4535	1	2	4	7	13
231	10405	6.5780	1	2	4	7	15
232	799	6.6083	1	2	4	7	17
233	5329	11.7467	3	5	9	15	23
234	3072	5.3865	1	2	4	7	11
235	6401	11.4805	2	4	7	12	24
236	39084	8.9773	2	4	7	10	17
237	1693	5.8328	2	3	6	7	10
238	6472	13.9322	4	6	10	17	28
239	60286	10.0598	3	5	9	18	19
240	11175	9.5085	3	4	7	11	18
241	4000	5.6287	2	3	6	7	11
242	2544	10.5491	3	5	8	13	22
243	106101	8.8511	2	3	5	9	13
244	11219	7.2646	2	3	5	8	14
245	5730	5.5081	1	2	4	6	10
246	1753	5.4780	2	3	4	7	10
247	9981	5.1535	1	2	4	6	10
248	6331	6.2402	2	3	5	7	12
249	8552	6.4259	1	2	4	6	13
250	3461	6.8050	2	3	5	8	13
251	3274	3.6130	1	2	3	4	7
253	17408	8.1683	2	3	6	9	16
254	12343	4.7343	1	2	3	4	9
255	2	2.5000	1	1	2	3	4
256	9411	5.4601	1	2	4	6	11
257	28803	5.1188	2	3	4	6	9
258	26586	3.6258	2	2	3	4	6
259	4071	5.9560	1	2	3	4	13
260	4863	2.5350	1	1	2	3	4
261	3080	2.8042	1	1	2	3	5
262	1286	3.5517	1	1	2	3	7
263	29564	20.5709	5	8	14	24	41

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
264	4234	11.3791	3	5	8	14	23
265	4999	9.8200	2	3	6	11	21
266	4190	4.4174	1	2	3	5	9
267	379	4.8021	1	1	3	5	11
268	1482	5.0628	1	1	2	5	9
269	11065	12.2933	2	4	9	15	25
270	5144	4.0072	1	2	3	5	8
271	20052	11.6591	3	5	8	13	21
272	6944	9.4241	3	5	7	11	18
273	2223	6.8277	2	3	5	8	14
274	3099	10.9935	2	4	7	13	21
275	383	5.6789	1	1	3	5	9
276	877	5.6328	1	1	4	7	11
277	72052	8.4759	3	5	7	10	15
278	26250	6.1446	3	4	5	7	10
279	6	7.0000	2	3	4	7	11
280	13349	6.8287	2	3	5	8	13
281	7419	4.1867	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5928	7.2763	2	3	5	8	14
284	2390	5.0753	1	2	4	6	9
285	4656	21.4021	5	9	15	25	41
286	1753	11.3440	5	6	12	21	39
287	6675	18.9768	5	7	12	21	39
288	533	10.1576	3	4	6	10	12
289	4013	5.6845	2	2	3	5	6
290	9686	3.4577	1	2	2	4	4
291	146	2.1027	1	1	2	2	4
292	5120	17.8982	4	7	13	22	35
293	496	7.4839	1	3	6	10	15
294	90766	7.2914	3	4	6	8	13
295	3379	5.8387	2	3	4	7	11
296	215338	8.3968	2	3	4	7	11
297	44861	5.2013	2	3	4	6	10
298	69	4.4638	1	2	2	5	9
299	888	6.6678	1	3	5	8	14
300	12045	9.3865	3	4	5	8	14
301	2085	5.3050	1	2	4	7	10
302	7144	15.9681	7	9	13	19	28
303	17590	13.3629	6	8	10	15	23
304	14273	13.5524	4	6	10	16	26
305	3538	6.4002	2	3	5	8	12
306	12338	8.8517	3	4	6	11	17
307	4245	4.5246	2	3	4	5	8
308	10437	9.0834	2	3	4	5	8
309	4429	3.9600	1	2	3	4	8
310	35678	5.6214	1	2	3	4	8
311	19461	2.6887	1	1	2	3	5
312	3139	5.5027	1	2	2	3	5
313	1844	2.7533	1	1	2	3	5
314	1	8.0000	8	8	8	8	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPEE V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
315	27894	12.3610	1	3	7	15	27
316	49895	9.1767	2	4	7	12	19
317	745	4.1195	1	2	3	4	8
318	6697	9.0769	2	3	6	11	19
319	839	3.9774	1	1	2	5	8
320	185178	8.4285	3	4	6	10	15
321	29299	5.8938	2	3	5	7	10
322	53	5.6038	2	3	5	7	9
323	20914	4.2820	1	2	3	5	5
324	13699	2.5722	1	1	2	3	11
325	9767	5.7981	2	3	4	7	11
326	3603	3.5795	1	2	3	4	7
327	10	8.5000	1	2	3	4	10
328	1298	4.9561	1	2	3	4	9
329	338	2.8787	1	1	2	3	5
331	30171	7.5097	2	3	6	9	15
332	5910	4.4795	1	2	3	5	9
333	339	7.6254	2	3	5	9	18
334	22733	9.1258	2	3	5	10	14
335	10704	7.2682	5	6	8	10	10
336	101256	5.7064	3	3	4	6	10
337	87102	3.8107	2	2	3	4	13
338	14297	6.1942	1	2	3	5	10
339	4685	4.8273	1	2	3	4	7
340	3	4.6667	3	3	3	5	8
341	13025	4.4253	1	2	3	4	9
342	416	3.8341	1	1	2	3	3
343	2	2.0000	1	1	2	3	10
344	4869	5.3828	1	2	3	5	10
345	2562	4.8989	1	2	3	5	17
346	7815	8.6271	2	3	6	10	9
347	925	4.4108	1	1	3	5	11
348	4360	5.7681	1	2	4	7	6
349	1841	3.0494	1	1	2	4	10
350	8153	5.8803	2	3	5	7	21
352	787	4.8475	1	3	5	6	14
353	2326	11.4596	5	8	9	14	21
354	9569	8.2302	4	5	9	14	14
355	6048	4.9854	3	4	6	9	7
356	31936	4.3107	2	3	5	8	7
357	6917	12.5038	5	7	10	15	23
358	23628	6.5656	3	4	5	7	11
359	27188	4.4800	3	3	4	5	6
360	9695	5.2309	2	3	4	5	9
361	448	5.5670	1	2	3	4	14
363	5796	4.3171	1	2	3	4	8
364	2694	4.1771	1	1	2	3	8
365	3201	10.7688	3	4	7	13	23
366	4975	10.1785	2	3	7	13	22
367	817	3.9584	1	1	3	4	8
368	1515	7.5129	2	4	6	9	14

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/82 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2542	4.547	1	2	3	6	9
370	883	7.040	3	4	5	7	11
371	764	4.419	3	3	4	5	6
372	443	3.731	1	2	3	4	6
373	2715	2.584	1	2	2	3	3
374	75	4.027	2	2	2	3	6
375	7	14.714	1	2	2	7	14
376	160	2.906	1	1	2	3	6
377	27	5.111	1	2	2	7	10
378	144	3.632	2	2	3	4	6
379	329	2.860	1	1	2	3	6
380	72	2.792	1	1	2	3	6
381	245	2.482	1	1	1	3	4
382	60	1.433	1	1	1	2	2
383	900	4.437	1	2	3	5	9
384	104	2.654	1	1	2	3	6
385	5	3.000	1	1	3	4	6
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
389	8	8.375	1	4	7	9	11
390	18	6.056	1	2	3	11	13
392	2500	14.038	5	7	10	18	27
394	1992	10.334	1	2	6	12	22
395	72540	6.472	2	3	5	8	13
396	13	3.154	1	1	2	2	5
397	12766	7.480	2	3	5	9	15
398	14721	8.382	3	4	6	10	15
399	1662	5.261	1	2	4	7	10
400	8125	13.401	3	5	9	17	28
401	6816	15.097	3	6	11	19	31
402	2346	5.159	1	2	3	7	11
403	28354	12.006	2	5	8	15	25
404	5255	5.683	1	2	4	7	12
405	5	2.000	1	2	2	3	3
406	3737	15.477	4	7	11	19	31
407	958	6.558	2	3	5	8	12
408	4841	8.490	1	2	5	10	20
409	7660	9.110	2	4	5	11	21
410	124349	3.621	1	2	3	5	6
411	162	3.272	1	1	2	4	7
412	157	2.892	1	1	2	4	6
413	9700	10.734	2	4	8	14	22
414	1716	6.115	1	4	8	14	22
415	29926	20.640	5	9	15	25	41
416	138291	10.414	2	5	8	13	19
417	47	5.532	2	3	5	7	8
418	14577	8.311	3	4	7	10	15
419	7412	7.497	2	4	6	9	14
420	3780	5.416	2	3	4	7	10
421	12412	5.645	2	3	4	7	10
422	109	6.156	2	3	5	7	12

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPEL V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
423	7323	11.226	3	5	8	13	22
424	2818	23.715	3	8	16	28	47
425	18133	6.508	2	3	4	8	13
426	8147	7.331	2	3	5	9	15
427	2046	7.858	1	3	5	9	15
428	1150	10.689	2	3	6	13	24
429	31113	12.334	3	4	7	13	24
430	57475	12.437	3	5	9	16	23
431	250	11.300	1	3	5	9	25
432	548	7.708	1	2	4	8	14
433	5992	4.500	1	1	3	5	15
434	17930	7.661	2	3	5	9	11
435	12858	6.344	2	3	5	9	15
436	2469	17.753	5	10	18	25	13
437	10763	16.620	6	10	15	23	28
439	971	9.550	1	3	6	12	22
440	4736	13.224	2	4	8	16	29
441	872	3.688	1	1	2	4	8
442	11761	9.987	1	3	6	12	21
443	6002	3.737	1	1	2	5	8
444	4028	7.426	2	3	5	8	13
445	2264	4.339	1	2	3	5	8
447	3187	3.543	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29594	6.013	1	2	4	7	12
450	7607	3.304	1	1	2	4	7
451	7	147.571	1	3	5	10	11
452	18057	6.266	1	2	4	7	13
453	5986	3.560	1	2	4	7	13
454	4165	7.084	1	2	4	8	14
455	1149	3.269	1	1	2	4	6
456	182	9.242	1	2	5	10	21
457	127	8.835	1	2	5	10	18
458	1650	22.930	5	10	17	30	45
459	585	14.899	3	6	11	18	30
460	2421	9.185	2	4	7	12	19
461	5377	5.533	1	1	2	5	13
462	6756	17.934	5	8	15	23	33
463	9499	6.760	2	3	5	8	13
464	2995	4.124	1	2	3	5	8
465	448	3.364	1	1	1	3	6
466	3722	5.015	1	1	2	4	10
467	3625	6.329	1	1	2	5	10
468	63800	19.120	4	8	14	23	37
471	7812	14.127	7	9	14	23	37
472	184	29.788	1	8	11	16	23
473	9381	17.072	2	4	10	26	41
475	75734	17.198	2	6	11	18	28
476	10935	17.198	6	10	14	20	29
477	37707	10.597	1	3	7	13	22
478	105147	10.267	2	4	7	13	21

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
479	17990	5.4611	1	2	5	7	10
480	117	40.2908	11	16	23	47	90
481	64	44.8906	23	31	37	50	72
482	6901	18.3908	6	9	13	21	35
483	34650	56.5558	17	28	44	69	105
484	316	23.1867	2	9	18	33	49
485	2647	17.1417	6	9	12	19	31
486	1932	17.5088	1	7	13	23	36
487	3112	11.3249	2	4	8	14	22
488	519	22.9518	5	10	16	27	44
489	4816	14.2091	3	5	10	17	29
490	1787	8.9485	2	3	5	10	19
491	6826	6.3898	3	4	5	8	11
492	998	14.3337	3	4	6	24	94
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		10357081					

BILLING CODE 4120-03-C

TABLE 8a.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)

State	Urban	Rural
Alabama	0.495	0.532
Alaska	0.657	0.883
Arizona	0.576	0.622
Arkansas	0.598	0.570
California	0.502	0.542
Colorado	0.570	0.620
Connecticut	0.645	0.688
Delaware	0.601	0.641
District of Columbia	0.574	
Florida	0.496	0.503
Georgia	0.593	0.581
Hawaii	0.573	0.772
Idaho	0.657	0.673
Illinois	0.553	0.621
Indiana	0.664	0.675
Iowa	0.610	0.729
Kansas	0.562	0.706
Kentucky	0.588	0.579
Louisiana	0.542	0.600
Maine	0.702	0.625
Maryland	0.765	0.806
Massachusetts	0.727	0.800
Michigan	0.560	0.660
Minnesota	0.634	0.721
Mississippi	0.627	0.583
Missouri	0.530	0.561
Montana	0.626	0.698
Nebraska	0.588	0.723
Nevada	0.478	0.681
New Hampshire	0.656	0.688
New Jersey	0.796	
New Mexico	0.524	0.580
New York	0.661	0.734
North Carolina	0.662	0.582
North Dakota	0.660	0.712
Ohio	0.626	0.659
Oklahoma	0.549	0.599
Oregon	0.613	0.680

TABLE 8a.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—Continued

State	Urban	Rural
Pennsylvania	0.510	0.602
Puerto Rico	0.526	0.620
Rhode Island	0.765	
South Carolina	0.551	0.545
South Dakota	0.627	0.688
Tennessee	0.573	0.572
Texas	0.548	0.653
Utah	0.620	0.641
Vermont	0.674	0.658
Virginia	0.576	0.595
Washington	0.703	0.740
West Virginia	0.598	0.563
Wisconsin	0.720	0.745
Wyoming	0.693	0.776

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)

State	Ratio
Alabama	0.062
Alaska	0.106
Arizona	0.082
Arkansas	0.065
California	0.051
Colorado	0.058
Connecticut	0.040
Delaware	0.065
District of Columbia	0.045
Florida	0.063
Georgia	0.061
Hawaii	0.057
Idaho	0.052
Illinois	0.053

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)—Continued

State	Ratio
Indiana	0.071
Iowa	0.064
Kansas	0.065
Kentucky	0.066
Louisiana	0.079
Maine	0.047
Maryland	0.058
Massachusetts	0.056
Michigan	0.058
Minnesota	0.060
Mississippi	0.059
Missouri	0.060
Montana	0.075
Nebraska	0.061
Nevada	0.053
New Hampshire	0.057
New Jersey	0.079
New Mexico	0.058
New York	0.062
North Carolina	0.055
North Dakota	0.073
Ohio	0.064
Oklahoma	0.068
Oregon	0.041
Pennsylvania	0.054
Puerto Rico	0.090
Rhode Island	0.042
South Carolina	0.069
South Dakota	0.076
Tennessee	0.068
Texas	0.071
Utah	0.063
Vermont	0.060
Virginia	0.068
Washington	0.084
West Virginia	0.067
Wisconsin	0.077
Wyoming	0.081

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
010001	10/01/90	09/30/91	1.2806	0.9979
010004	10/01/90	09/30/91	0.9033	0.9616
010005	10/01/90	09/30/91	1.1249	0.9743
010007	10/01/90	09/30/91	1.1007	0.9635
010008	10/01/90	09/30/91	1.0048	0.9708
010009	08/01/90	07/31/91	1.0238	0.9660
010010	10/01/90	09/30/91	1.1145	0.9681
010016	10/01/90	09/30/91	1.0753	0.9774
010019	10/01/90	09/30/91	1.1702	0.9869
010020	07/01/90	11/20/91	1.0085	0.9690
010021	10/01/90	09/30/91	1.2109	0.9802
010029	10/01/90	09/30/91	1.4918	0.9964
010032	01/01/91	12/31/91	0.8937	0.9142
010033	10/01/90	09/30/91	1.9478	0.9962
010035	10/01/90	09/30/91	1.1651	0.9755
010040	01/01/91	12/31/91	1.3049	0.9890
010043	10/01/90	09/30/91	0.9482	0.9536
010044	10/01/90	09/30/91	0.9697	0.9678
010045	10/01/90	09/30/91	1.0115	0.9725
010046	07/01/90	07/31/91	1.3105	0.9906
010047	10/01/90	09/30/91	0.9033	0.9738
010049	09/01/90	08/31/91	1.0894	0.9756
010051	10/01/90	09/30/91	0.8599	0.9590
010052	10/01/90	09/30/91	0.9563	0.9122
010053	07/01/90	09/30/91	1.0054	0.9477
010059	10/01/90	09/30/91	0.9973	0.9683
010061	10/01/90	09/30/91	0.9575	0.9669
010062	10/01/90	09/30/91	0.9491	0.9778

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
010065	01/01/91	12/31/91	1.1990	0.9549
010069	10/01/90	09/30/91	1.1602	0.9505
010073	10/01/90	09/30/91	0.8982	0.9292
010079	10/01/90	09/30/91	1.1474	0.9719
010081	09/01/90	08/31/91	1.8118	0.9952
010083	10/01/90	09/30/91	1.0972	0.9534
010084	01/01/91	12/31/91	1.2941	0.9972
010087	10/01/90	09/30/91	1.5170	0.9965
010092	10/01/90	09/30/91	1.3697	0.9999
010094	09/01/90	08/31/91	1.1874	0.9758
010095	10/01/90	09/30/91	1.0125	0.9462
010096	10/01/90	09/30/91	0.9047	0.9716
010097	10/01/90	09/30/91	1.0062	0.9688
010099	10/01/90	09/30/91	1.0895	0.9614
010100	10/01/90	09/30/91	1.1675	0.9821
010102	10/01/90	09/30/91	0.9123	0.9609
010108	11/01/90	10/31/91	1.1574	0.9745
010109	10/01/90	09/30/91	1.0718	0.9889
010110	10/01/90	09/30/91	0.9068	0.9665
010112	10/01/90	09/30/91	1.1465	0.9662
010115	10/01/90	09/30/91	0.8956	0.9389
010117	10/01/90	09/30/91	1.1192	1.0000
010119	10/01/90	09/30/91	1.1919	0.9942
010120	10/01/90	09/30/91	0.9815	0.9669
010122	01/01/91	12/31/91	0.9541	0.9658
010123	09/01/90	08/31/91	1.2749	0.9815
010124	09/01/90	08/31/91	1.2798	0.9876
010125	10/01/90	09/30/91	1.0998	0.9682
010126	10/01/90	09/30/91	1.0810	0.9709
010127	09/01/90	08/31/91	1.4985	0.9980
010129	10/01/90	09/30/91	1.0510	0.9460
010130	10/01/90	09/30/91	1.1140	0.9612
010137	10/01/90	09/30/91	1.2943	0.9938
010139	01/01/91	12/31/91	1.5773	0.9992
010143	10/01/90	09/30/91	1.1302	0.9731
010144	01/01/91	12/31/91	1.3851	0.9871
010146	10/01/90	09/30/91	1.0477	0.9549
010149	09/01/90	08/31/91	1.3679	0.9915
010152	10/01/90	09/30/91	1.2562	0.9839
010153	10/01/90	09/30/91	0.8914	1.0000
010155	10/01/90	09/30/91	1.1262	0.9360
020001	01/01/91	12/31/91	1.4626	0.9975
020005	10/01/90	09/30/91	0.8931	0.9364
020006	01/01/91	12/31/91	1.0309	0.9708
020012	01/01/91	12/31/91	1.1408	0.9917
020013	01/01/91	12/31/91	0.9180	0.9697
020017	09/01/90	08/31/91	1.3624	0.9902
020025	01/01/91	12/31/91	1.0106	0.9611
030001	01/01/91	12/31/91	1.3279	0.9860
030002	01/01/91	12/31/91	1.7477	0.9970
030004	10/01/90	09/30/91	0.9790	0.9878
030008	09/01/90	08/31/91	1.8840	0.9989
030012	01/01/91	12/31/91	1.2553	0.9815
030013	10/01/90	09/30/91	1.2358	0.9866
030014	01/01/91	12/31/91	1.4202	0.9976
030018	01/01/91	12/31/91	1.6005	0.9985
030023	01/01/91	12/31/91	1.2270	0.9842
030025	01/01/91	12/31/91	1.0695	0.9510
030030	09/01/90	08/31/91	1.6606	0.9994
030035	01/01/91	12/31/91	1.2880	0.9923
030036	01/01/91	12/31/91	1.2311	0.9895
030038	10/01/90	09/30/91	1.4609	0.9990
030041	01/01/91	12/31/91	0.9364	0.9179
030044	10/01/90	09/30/91	1.1153	0.9496
030046	01/01/91	12/31/91	0.9388	0.9615
030047	01/01/91	12/31/91	0.8914	0.9778
030051	07/01/90	09/30/91	1.0618	0.9832
030060	01/01/91	12/31/91	1.0843	0.9703
030061	01/01/91	12/31/91	1.4526	0.9986
030062	01/01/91	12/31/91	1.2974	0.9562
030065	01/01/91	12/31/91	1.4786	0.9980
030067	10/01/90	09/30/91	1.0451	0.9575
030068	01/01/91	12/31/91	0.9909	0.9485
030069	01/01/91	12/31/91	1.3126	0.9724
030083	09/01/90	08/31/91	1.3389	0.9837
030085	09/01/90	08/31/91	1.3875	0.9869
030086	09/01/90	08/31/91	1.1940	0.9428

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
030087	10/01/90	09/30/91	1.6019	0.9888
030088	01/01/91	12/31/91	1.2877	0.9884
030089	01/01/91	12/31/91	1.2560	0.9857
030092	01/01/91	12/31/91	1.4852	0.9848
030093	01/01/91	12/31/91	1.3038	0.9884
030094	09/01/90	08/31/91	1.2987	0.9878
040004	01/01/91	12/31/91	1.2316	0.9958
040005	10/01/90	09/30/91	1.0551	0.9494
040007	10/01/90	09/30/91	1.5315	0.9983
040010	01/01/91	12/31/91	1.1608	0.9869
040013	01/01/90	07/31/91	0.9809	0.9818
040014	09/01/90	08/31/91	1.0982	0.9694
040015	07/01/90	09/30/91	1.0368	0.9148
040018	01/01/91	12/31/91	1.2256	0.9875
040020	10/01/90	09/30/91	1.4571	0.9982
040021	01/01/91	12/31/91	1.2200	0.9941
040024	10/01/90	09/30/91	1.0829	0.9468
040027	01/01/91	12/31/91	1.2885	0.9851
040028	10/01/90	09/30/91	0.9933	0.9736
040029	01/01/91	12/31/91	1.1117	0.9750
040031	01/01/91	12/31/91	0.9701	0.9414
040036	01/01/91	12/31/91	1.2251	0.9921
040041	09/01/90	08/31/91	1.1306	0.9836
040042	01/01/91	12/31/91	1.3007	0.9870
040044	01/01/91	12/31/91	0.9470	0.9568
040045	01/01/91	12/31/91	0.9433	0.9360
040047	01/01/91	12/31/91	1.0528	0.9731
040050	10/01/90	09/30/91	1.1125	0.9720
040064	01/01/91	12/31/91	0.9004	0.9194
040066	01/01/91	12/31/91	1.0686	0.9637
040067	10/01/90	09/30/91	1.0005	0.9688
040072	12/01/90	11/30/91	1.0641	0.9620
040075	01/01/91	12/31/91	1.1147	0.9643
040078	01/01/91	12/31/91	1.2373	0.9900
040081	10/01/90	09/30/91	0.8827	0.9536
040085	01/01/91	12/31/91	1.1474	0.9611
040100	01/01/91	12/31/91	1.1281	0.9884
040105	10/01/90	09/30/91	1.0121	0.9493
040106	10/01/90	09/30/91	1.1808	0.9667
040107	10/01/90	09/30/91	1.0510	0.9564
040114	01/01/91	12/31/91	1.7152	0.9991
040118	01/01/91	12/31/91	1.2038	0.9842
040119	10/01/90	09/30/91	1.1353	0.9883
050002	10/01/90	09/30/91	1.3008	0.9874
050007	01/01/91	12/31/91	1.4866	0.9971
050008	01/01/91	12/31/91	1.4389	0.9889
050013	01/01/91	12/31/91	2.0998	0.9969
050016	01/01/90	12/31/91	1.1762	0.9858
050021	09/01/90	08/31/91	1.2998	0.9777
050022	01/01/91	12/31/91	1.5182	0.9964
050024	01/01/91	12/31/91	1.3870	0.9913
050030	12/01/90	11/30/91	1.2991	0.9888
050032	09/01/90	08/31/91	1.2768	0.9825
050043	09/01/90	08/31/91	1.5657	0.9988
050047	06/17/90	12/31/91	1.6993	0.9980
050053	01/01/91	12/31/91	1.3473	0.9966
050058	10/01/90	09/30/91	1.4050	0.9973
050061	08/01/90	08/31/91	1.4669	0.9974
050070	09/01/90	08/31/91	1.2586	0.9829
050071	01/01/91	12/31/91	1.2068	0.9802
050072	01/01/91	12/31/91	1.3136	0.9851
050073	01/01/91	12/31/91	1.2479	0.9843
050074	01/01/91	12/31/91	1.2152	0.9855
050075	01/01/91	12/31/91	1.0190	0.9606
050076	01/01/91	12/31/91	1.3040	0.9894
050078	01/01/91	12/31/91	1.4446	0.9548
050080	01/01/91	12/31/91	1.3510	0.9923
050081	01/01/91	12/31/91	1.2326	0.9922
050084	09/01/90	08/31/91	1.8385	0.9853
050091	01/01/91	12/31/91	1.5145	0.9989
050096	09/01/90	08/31/91	1.2531	0.9922
050097	01/01/91	12/31/91	1.0380	1.0000
050099	01/01/91	12/31/91	1.4292	0.9938
050100	12/30/90	12/29/91	1.6728	0.9954
050101	10/01/90	09/30/91	1.8267	0.9962
050102	01/01/91	12/31/91	1.3792	0.9882
050102	01/01/91	12/31/91	1.3268	0.9908

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050103	01/01/91	12/31/91	1.4915	0.9969
050107	12/01/90	11/30/91	1.3609	0.9871
050108	01/01/91	12/31/91	1.4254	0.9849
050109	01/01/91	12/31/91	2.1164	0.9973
050111	01/01/91	12/31/91	1.2680	0.9983
050112	10/01/90	09/30/91	1.4461	0.9989
050117	01/01/91	12/31/91	1.2730	0.9948
050121	01/01/91	12/31/91	1.2924	0.9847
050122	01/01/91	12/31/91	1.4411	0.9988
050125	01/01/91	12/31/91	1.2931	0.9862
050126	11/01/90	10/31/91	1.4070	0.9970
050127	10/01/90	09/30/91	1.2631	0.9847
050131	01/01/91	12/31/91	1.2296	0.9802
050132	10/01/90	09/30/91	1.4021	0.9939
050135	10/01/90	09/30/91	1.3064	0.9991
050137	01/01/91	12/31/91	1.2754	0.9839
050138	01/01/91	12/31/91	1.7056	0.9927
050139	01/01/91	12/31/91	1.2103	0.9934
050140	01/01/91	12/31/91	1.3111	0.9832
050144	09/01/90	08/31/91	1.4833	0.9925
050145	01/01/91	12/31/91	1.2967	0.9836
050146	10/01/90	09/30/91	1.3043	1.0000
050149	10/01/90	09/30/91	1.3563	0.9898
050150	01/01/91	12/31/91	1.2240	0.9780
050154	10/01/90	09/30/91	1.2227	0.9811
050155	10/01/90	09/30/91	1.1176	0.9957
050169	10/01/90	09/30/91	1.4898	0.9957
050173	09/01/90	08/31/91	1.2582	0.9854
050180	12/31/90	12/29/91	1.4345	0.9976
050186	09/01/90	09/30/91	1.3260	0.9806
050189	10/01/90	09/30/91	0.9175	0.9862
050196	01/01/91	12/31/91	1.2952	0.9865
050204	10/01/90	09/30/91	1.4014	0.9963
050205	01/01/91	12/31/91	1.2380	0.9963
050208	01/01/91	12/31/91	1.2087	0.9980
050211	01/01/91	12/31/91	1.3405	0.9937
050212	09/01/90	08/31/91	1.1018	0.9934
050214	01/01/91	12/31/91	1.5519	0.9877
050217	01/01/91	12/31/91	1.2153	0.9642
050222	10/01/90	09/30/91	1.5354	0.9979
050224	09/16/90	09/14/91	1.6166	0.9990
050225	01/01/91	12/31/91	1.3236	0.9861
050226	10/01/90	09/30/91	1.4272	0.9988
050231	01/01/91	12/31/91	1.5130	0.9955
050233	10/01/90	09/30/91	1.2236	0.9849
050234	10/01/90	09/30/91	1.2822	0.9911
050235	01/01/91	12/31/91	1.4983	0.9975
050236	01/01/91	12/31/91	1.3921	0.9835
050238	01/01/91	12/31/91	1.4902	0.9930
050239	01/01/91	12/31/91	1.4077	0.9966
050241	01/01/91	12/31/91	1.3074	0.9807
050251	01/01/91	12/31/91	1.1612	0.9684
050254	11/01/90	10/31/91	1.1369	0.9843
050256	11/01/90	10/31/91	1.6747	0.9938
050257	01/01/91	12/31/91	1.1540	0.9872
050264	09/01/90	08/31/91	1.4151	0.9939
050269	10/01/90	09/30/91	1.1091	0.9889
050270	10/01/90	09/30/91	1.3154	0.9850
050272	10/01/90	09/30/91	1.3150	0.9937
050281	10/01/89	08/31/91	1.2894	0.9870
050282	10/01/90	09/30/91	1.2798	0.9879
050286	08/01/90	07/31/91	1.0042	0.9595
050298	01/01/91	12/31/91	1.2365	0.9731
050300	01/01/91	12/31/91	1.2973	0.9920
050301	01/01/91	12/31/91	1.2100	0.9856
050302	01/01/91	12/31/91	1.3079	0.9869
050305	12/30/90	12/28/91	1.4793	0.9970
050309	01/01/91	12/31/91	1.2928	0.9947
050310	09/01/90	08/31/91	1.2163	0.9954
050313	01/01/91	12/31/91	1.1417	0.9807
050317	01/01/91	12/31/91	1.2356	0.9832
050324	10/01/90	09/30/91	1.8415	0.9958
050327	01/01/91	12/31/91	1.6237	0.9984
050328	09/01/90	09/30/91	1.2638	0.9702
050335	01/01/91	12/31/91	1.2144	0.9847
050336	01/01/91	12/31/91	1.2404	0.9715
050345	10/01/90	09/30/91	1.3643	0.9851

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050351	01/01/91	12/31/91	1.5234	0.9970
050352	01/01/91	12/31/91	1.2688	0.9669
050357	10/01/90	09/30/91	1.8316	0.9963
050363	09/01/90	08/31/91	1.3268	0.9689
050367	01/01/91	12/31/91	1.2458	0.9754
050369	01/01/91	12/31/91	1.2762	0.9920
050385	09/01/90	07/31/91	1.2892	0.9777
050391	01/01/91	12/31/91	1.4138	0.9865
050394	01/01/91	12/31/91	1.4959	0.9973
050396	01/01/91	12/31/91	1.5996	0.9994
050404	01/01/91	12/31/91	1.0486	0.9768
050407	01/01/91	12/31/91	1.0963	0.9990
050411	01/01/91	12/31/91	1.3220	0.9875
050417	01/01/91	12/31/91	1.1814	0.9748
050420	01/01/91	12/31/91	1.4096	0.9910
050424	09/01/90	10/31/91	1.7034	0.9985
050425	01/01/91	12/31/91	1.3113	0.9810
050426	09/01/90	08/31/91	1.3808	0.9947
050427	09/01/90	08/31/91	0.9550	0.9405
050431	09/01/90	08/31/91	1.0762	0.9948
050438	10/01/90	09/30/91	1.4842	0.9959
050440	01/01/91	12/31/91	1.1946	0.9895
050441	09/01/90	08/31/91	1.7438	0.9962
050447	09/01/90	08/31/91	1.0444	0.9824
050455	01/01/91	12/31/91	1.8769	0.9975
050456	07/01/90	12/31/91	1.3619	0.9932
050458	01/01/91	12/31/91	0.9534	0.9957
050467	01/01/91	12/31/91	1.2552	0.9870
050469	01/01/91	12/31/91	1.0711	0.9761
050471	09/01/90	08/31/91	1.7495	0.9963
050476	01/01/91	12/31/91	1.0330	0.9500
050481	09/01/90	08/31/91	1.4876	0.9973
050483	10/01/90	09/30/91	1.2361	0.9966
050486	10/01/90	09/30/91	1.4179	0.9916
050489	10/01/90	09/30/91	1.0753	0.9903
050492	09/01/90	08/31/91	1.2800	0.9699
050498	01/01/91	12/31/91	1.1677	0.9855
050503	10/01/90	09/30/91	1.2974	0.9799
050506	08/01/90	07/31/91	1.4945	0.9903
050510	01/01/91	12/31/91	1.3104	0.9843
050512	01/01/91	12/31/91	1.2588	0.9853
050515	01/01/91	12/31/91	1.3251	0.9876
050517	10/01/90	09/30/91	1.3935	0.9885
050523	01/01/91	12/31/91	1.2478	0.9750
050526	09/01/90	08/31/91	1.3600	0.9717
050531	09/01/90	08/31/91	1.2749	0.9969
050537	01/01/91	12/31/91	1.2256	0.9786
050541	01/01/91	12/31/91	1.5068	0.9819
050543	01/01/91	12/31/91	1.3113	0.9857
050549	01/01/91	12/31/91	1.7702	0.9960
050550	09/01/90	08/31/91	1.1381	0.9886
050552	01/01/91	12/31/91	1.0558	0.9931
050557	10/01/90	09/30/91	1.5128	0.9973
050561	01/01/91	12/31/91	1.1930	0.9900
050567	01/01/91	12/31/91	1.6044	0.9963
050570	11/01/90	10/31/91	1.7032	0.9954
050571	10/01/90	09/30/91	1.4060	0.9914
050575	10/01/90	09/30/91	1.2209	0.9956
050580	01/01/91	12/31/91	1.2294	0.9921
050585	01/01/91	12/31/91	1.3795	0.9776
050586	09/01/90	08/31/91	1.3275	0.9910
050587	01/01/91	12/31/91	1.2731	0.9974
050588	09/01/90	08/31/91	1.2534	0.9833
050590	01/01/91	12/31/91	1.3090	0.9881
050591	09/01/90	08/31/91	1.1298	0.9923
050592	09/01/90	08/31/91	1.3014	0.9829
050593	01/01/91	12/31/91	1.2678	0.9674
050597	10/01/90	09/30/91	1.3688	0.9880
050604	01/01/91	12/31/91	1.4412	0.9721
050607	10/01/89	08/31/91	1.2518	0.9873
050609	01/01/91	12/31/91	1.2982	0.9907
050619	01/01/91	12/31/91	1.3745	0.9882
050622	09/01/90	08/31/91	1.0701	0.9718
050624	10/01/90	09/30/91	1.2750	0.9817
050630	01/01/91	12/31/91	1.2385	0.9747
050635	01/01/91	12/31/91	1.2936	0.9913
050644	09/01/90	08/31/91	1.1627	0.9888

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050655	01/01/91	12/31/91	0.8693	0.9974
050663	10/01/90	09/30/91	1.0987	0.9986
050669	01/01/90	08/31/91	0.9242	1.0000
050670	09/01/90	08/31/91	1.1533	1.0000
050674	01/01/91	12/31/91	1.1965	0.9903
050677	01/01/91	12/31/91	1.3197	0.9860
050680	01/01/91	12/31/91	1.2462	0.9631
050686	01/01/91	12/31/91	1.2746	0.9891
050690	01/01/91	12/31/91	1.1858	0.9870
050695	01/01/91	12/31/91	1.2087	0.9708
060001	01/01/91	12/31/91	1.4559	0.9886
060003	01/01/91	12/31/91	1.2114	0.9903
060004	01/01/91	12/31/91	1.1098	0.9691
060006	01/01/91	12/31/91	1.1637	0.9859
060007	01/01/91	12/31/91	1.1789	0.9553
060009	01/01/91	12/31/91	1.3666	0.9958
060010	01/01/91	12/31/91	1.5334	0.9981
060011	01/01/91	12/31/91	1.2187	0.9845
060014	09/01/90	08/31/91	1.6526	0.9972
060018	01/01/91	12/31/91	1.1693	0.9792
060022	01/01/91	12/31/91	1.5931	0.9982
060027	01/01/91	12/31/91	1.4496	0.9979
060029	01/01/91	12/31/91	0.9594	0.9537
060030	01/01/91	12/31/91	1.3232	0.9933
060033	01/01/91	12/31/91	1.1362	0.9679
060034	01/01/91	12/31/91	1.3456	0.9921
060037	01/01/91	12/31/91	0.9974	0.9319
060038	01/01/91	12/31/91	1.1011	0.9799
060041	01/01/91	12/31/91	1.1076	1.0000
060042	01/01/91	12/31/91	0.9639	0.9708
060043	01/01/91	12/31/91	0.8738	0.9249
060044	01/01/91	12/31/91	1.1889	0.9839
060046	01/01/91	12/31/91	1.0796	0.9578
060047	01/01/91	12/31/91	1.0260	0.9755
060049	01/01/91	12/31/91	1.0374	0.9543
060050	01/01/91	12/31/91	1.2399	0.9705
060052	01/01/91	12/31/91	1.0298	0.9639
060053	01/01/91	12/31/91	1.1423	0.9683
060056	01/01/91	12/31/91	0.8923	0.9838
060057	01/01/91	12/31/91	1.0223	0.9577
060058	01/01/91	12/31/91	0.9001	0.9160
060060	01/01/91	12/31/91	1.0425	0.9648
060062	01/01/91	12/31/91	1.0011	0.9391
060063	01/01/91	12/31/91	1.1814	0.9560
060064	01/01/91	12/31/91	1.3824	0.9963
060065	09/01/90	08/31/91	1.3251	0.9933
060066	01/01/91	12/31/91	0.9405	0.9222
060068	01/01/91	12/31/91	1.1586	0.9807
060070	01/01/91	12/31/91	1.2129	0.9739
060071	01/01/91	12/31/91	1.1363	0.9832
060072	10/01/90	09/30/91	0.9170	0.9707
060073	01/01/91	12/31/91	0.9947	0.9576
060075	01/01/91	12/31/91	1.3080	0.9869
060076	01/01/91	12/31/91	1.4055	0.9798
060085	01/01/91	12/31/91	0.8981	0.9379
060087	09/01/90	08/31/91	1.3945	0.9955
060088	01/01/91	12/31/91	1.1193	0.9236
060090	01/01/91	12/31/91	0.8710	0.9037
060096	11/01/90	10/31/91	0.9925	0.8964
060100	09/01/90	08/31/91	1.3806	0.9847
060101	10/01/90	09/30/91	1.4281	0.9686
060103	01/01/91	12/31/91	1.3073	0.9866
070001	10/01/90	09/30/91	1.7864	0.9995
070002	10/01/90	09/30/91	1.7801	0.9992
070003	10/01/90	09/30/91	1.1602	0.9803
070004	10/01/90	09/30/91	1.1337	0.9843
070005	10/01/90	09/30/91	1.2836	0.9914
070006	10/01/90	09/30/91	1.2742	0.9945
070007	10/01/90	09/30/91	1.3699	0.9919
070008	10/01/90	09/30/91	1.2371	0.9920
070009	10/01/90	09/30/91	1.2983	0.9898
070010	10/01/90	09/30/91	1.4679	0.9987
070011	10/01/90	09/30/91	1.2026	0.9899
070012	10/01/90	09/30/91	1.2419	0.9883
070013	10/01/90	09/30/91	1.3405	0.9914
070014	10/01/90	09/30/91	1.2877	0.9888
070015	10/01/90	09/30/91	1.2395	0.9902

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
070016	10/01/90	09/30/91	1.2969	0.9925
070017	10/01/90	09/30/91	1.2922	0.9860
070018	10/01/90	09/30/91	1.3006	0.9971
070019	10/01/90	09/30/91	1.1696	0.9872
070020	10/01/90	09/30/91	1.3970	0.9892
070021	10/01/90	09/30/91	1.2044	0.9883
070022	10/01/90	09/30/91	1.6748	0.9973
070023	10/01/90	09/30/91	1.2601	0.9997
070024	10/01/90	09/30/91	1.1922	0.9921
070025	10/01/90	09/30/91	1.6628	0.9987
070026	10/01/90	09/30/91	1.2425	0.9873
070027	10/01/90	09/30/91	1.2145	0.9876
070028	10/01/90	09/30/91	1.4915	0.9997
070029	10/01/90	09/30/91	1.2279	0.9916
070030	10/01/90	09/30/91	1.2667	0.9974
070031	10/01/90	09/30/91	1.3122	0.9942
070033	10/01/90	09/30/91	1.3514	0.9924
070034	10/01/90	09/30/91	1.2992	0.9947
070035	10/01/90	09/30/91	1.3613	0.9913
070036	10/01/90	09/30/91	1.3474	0.9812
080005	10/01/90	09/30/91	1.1994	0.9941
090002	01/01/91	12/31/91	1.1861	0.8887
090005	01/01/91	12/31/91	1.2739	0.9979
090006	01/01/91	12/31/91	1.3121	0.9957
090007	10/01/90	09/30/91	1.2718	0.9919
090008	01/01/91	12/31/91	1.4030	0.9948
100001	10/01/90	09/30/91	1.3979	0.9968
100002	10/01/90	09/30/91	1.4242	0.9869
100004	10/01/90	09/30/91	1.0139	0.9353
100005	10/01/90	09/30/91	0.9150	0.9947
100006	10/01/90	09/30/91	1.6152	0.9957
100007	01/01/91	12/31/91	1.8834	0.9971
100008	10/01/90	09/30/91	1.7167	0.9982
100009	10/01/90	09/30/91	1.4240	0.9971
100012	10/01/90	09/30/91	1.5506	0.9993
100014	10/01/90	09/30/91	1.3297	0.9919
100015	08/01/90	07/31/91	1.4013	0.9953
100017	10/01/90	09/30/91	1.6843	0.9957
100018	10/01/90	09/30/91	1.3548	0.9883
100019	10/01/90	09/30/91	1.4874	0.9995
100020	12/01/90	11/30/91	1.3329	0.9942
100021	01/01/91	12/31/91	1.2859	1.0000
100022	10/01/90	09/30/91	1.6075	0.9965
100023	10/01/90	09/30/91	1.3262	0.9831
100024	10/01/90	09/30/91	1.2642	0.9888
100025	01/01/91	12/31/91	1.5216	0.9985
100026	10/01/90	09/30/91	1.4238	0.9998
100028	10/01/90	09/30/91	1.2986	0.9761
100029	10/01/90	09/30/91	1.3179	0.9963
100030	10/01/90	09/30/91	1.2694	0.9963
100034	01/01/91	12/31/91	1.6251	0.9994
100035	09/01/90	08/31/91	1.4645	1.0000
100040	01/01/91	12/31/91	1.6537	0.9979
100042	01/01/91	12/31/91	1.2427	0.9863
100043	10/01/90	09/30/91	1.3729	0.9890
100044	10/01/90	09/30/91	1.4161	0.9906
100045	10/01/90	09/30/91	1.3927	0.9871
100046	01/01/91	12/31/91	1.3332	0.9770
100047	01/01/91	12/31/91	1.5832	0.9952
100048	10/01/90	09/30/91	0.9471	0.9662
100049	10/01/90	09/30/91	1.3533	0.9760
100050	01/01/91	12/31/91	1.2197	0.9961
100052	10/01/90	09/30/91	1.2863	0.9564
100053	10/01/90	09/30/91	1.3213	0.9875
100054	10/01/90	09/30/91	1.2657	0.9959
100055	08/01/90	07/31/91	1.3924	0.9699
100056	10/01/90	09/30/91	1.3559	0.9890
100057	01/01/91	12/31/91	1.5678	0.9851
100060	10/01/90	09/30/91	1.3489	0.9575
100061	01/01/91	12/31/91	1.7888	0.9992
100062	09/01/90	08/31/91	1.4929	0.9976
100063	10/01/90	09/30/91	1.6836	0.9988
100065	01/01/91	12/31/91	1.2967	0.9850
100069	10/01/90	09/30/91	1.2930	0.9986
100071	01/01/91	12/31/91	1.3789	0.9927
100072	10/01/90	09/30/91	1.3921	0.9868
	10/01/90	09/30/91	1.1723	0.9835

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
100074	10/01/90	09/30/91	1.2318	0.9903
100077	09/01/90	08/31/91	1.3139	0.9849
100078	10/01/90	09/30/91	1.1488	0.9824
100080	10/01/90	09/30/91	1.5859	0.9990
100081	10/01/90	09/30/91	1.0962	0.9802
100082	10/01/90	09/30/91	1.3658	0.9971
100085	01/01/91	12/31/91	1.3818	0.9905
100087	10/01/90	09/30/91	1.7277	0.9991
100088	10/01/90	09/30/91	1.5083	0.9979
100089	01/01/91	12/31/91	1.2736	0.9863
100090	10/01/90	09/30/91	1.2997	0.9846
100092	10/01/90	09/30/91	1.3270	0.9975
100093	10/01/90	09/30/91	1.5352	0.9938
100098	10/01/90	09/30/91	1.0270	0.9841
100099	10/01/90	09/30/91	1.2802	0.9500
100100	01/01/91	12/31/91	1.2708	0.9970
100102	10/01/90	09/30/91	1.2016	0.9732
100103	10/01/90	09/30/91	1.0130	0.9657
100105	10/01/90	09/30/91	1.3795	0.9860
100107	09/01/90	08/31/91	1.2546	0.9865
100108	10/01/90	09/30/91	1.0990	0.9794
100109	01/01/91	12/31/91	1.2573	0.9724
100110	09/01/90	08/31/91	1.3800	0.9909
100112	10/01/89	07/24/91	0.9678	0.9561
100117	10/01/90	09/30/91	1.2988	0.9701
100118	11/01/90	10/31/91	1.1560	0.9889
100121	10/01/90	09/30/91	1.1162	0.9613
100124	11/01/90	10/31/91	1.2825	0.9760
100127	10/01/90	09/30/91	1.5842	0.9989
100128	10/01/90	09/30/91	2.2783	0.9962
100129	12/01/89	09/10/91	1.4226	0.9884
100130	10/01/90	09/30/91	1.1908	0.9871
100131	09/01/90	08/31/91	1.2109	0.9917
100132	01/01/91	12/31/91	1.3270	0.9730
100134	10/01/90	09/30/91	0.9827	0.9355
100135	10/01/90	09/30/91	1.5133	0.9989
100137	10/01/90	09/30/91	1.1369	0.9656
100138	10/01/90	09/30/91	0.9754	0.9810
100139	10/01/90	09/30/91	1.0576	0.9640
100140	10/01/90	09/30/91	1.1144	0.9697
100142	10/01/90	08/30/91	1.1523	0.9763
100143	01/01/91	12/31/91	1.2722	0.9903
100144	10/01/90	09/30/91	1.2340	0.9905
100146	10/01/90	09/30/91	1.0764	0.9684
100147	10/01/90	09/30/91	1.0828	0.9763
100151	01/01/91	12/31/91	1.7245	0.9996
100154	10/01/90	09/30/91	1.6110	0.9983
100156	11/01/90	10/31/91	1.0674	0.9707
100157	10/01/90	09/30/91	1.4942	0.9993
100159	10/01/90	09/30/91	1.0490	0.9612
100162	10/01/90	09/30/91	1.2998	0.9901
100164	10/01/90	09/30/91	0.9793	1.0000
100165	01/01/91	12/31/91	1.1044	0.9920
100169	11/01/90	10/31/91	1.8109	0.9990
100170	10/01/90	09/30/91	1.4183	0.9949
100173	10/01/90	09/30/91	1.5686	0.9995
100174	10/01/90	08/30/91	1.3610	0.9950
100175	10/01/90	09/30/91	1.0950	0.9713
100176	10/01/90	09/30/91	1.9619	0.9958
100177	10/01/90	09/30/91	1.3381	0.9913
100180	09/01/90	08/31/91	1.4086	0.9956
100181	12/01/90	11/30/91	1.2829	0.9975
100183	01/01/91	12/31/91	1.3537	0.9988
100185	10/01/90	09/30/91	1.2176	0.9024
100186	12/18/90	12/31/91	1.3317	0.9875
100187	01/01/91	12/31/91	1.3433	0.9917
100189	01/01/91	12/31/91	1.3387	0.9844
100194	09/01/90	10/14/91	1.2668	0.9962
100196	09/01/90	08/31/91	1.2388	0.9924
100199	09/01/90	08/31/91	1.1906	0.9963
100203	09/01/90	09/29/91	1.1278	0.9973
100206	12/01/90	11/30/91	1.3591	0.9908
100208	01/01/91	12/31/91	1.4739	0.9929
100209	08/01/90	12/31/91	1.5331	0.9987
100210	01/01/91	12/31/91	1.7034	0.9979
100211	09/01/90	08/31/91	1.2691	0.9863
100212	09/01/90	08/31/91	1.6306	0.9981

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
100217	09/01/90	08/31/91	1.1724	0.9780
100219	09/01/90	10/31/91	1.3843	0.9864
100220	01/01/91	12/31/91	1.7197	0.9995
100221	09/01/90	08/31/91	1.5183	0.9978
100222	01/01/90	11/04/91	1.2342	0.9889
100223	09/01/90	08/31/91	1.4171	0.9857
100224	01/01/91	12/31/91	1.3665	0.9836
100226	09/01/90	08/31/91	1.3133	0.9921
100227	09/01/90	08/31/91	0.9756	0.9881
100228	09/01/90	08/31/91	1.2731	0.9866
100229	09/01/90	08/31/91	1.4823	0.9890
100232	10/01/90	09/30/91	1.3071	0.9853
100234	09/01/90	08/31/91	1.3369	0.9909
100235	09/01/90	09/29/91	1.3401	0.9922
100237	10/01/90	09/30/91	2.0922	0.9990
100238	09/01/90	08/31/91	1.4011	0.9924
100241	10/01/90	09/30/91	0.9984	0.9707
100243	09/01/90	08/31/91	1.3848	0.9876
100248	01/01/91	12/31/91	1.3591	0.9943
100248	08/01/90	07/31/91	1.6899	0.9990
100253	10/01/90	09/30/91	1.3647	0.9817
100255	01/01/91	12/31/91	1.3552	0.9861
100259	09/01/90	08/31/91	1.4203	0.9706
100260	10/01/90	09/30/91	1.4024	0.9889
100262	10/01/90	09/30/91	1.3347	0.9912
100263	09/01/90	08/31/91	1.4559	0.9837
100265	10/01/90	09/30/91	1.2841	0.9858
100266	10/01/90	09/30/91	1.3137	0.9866
100267	01/01/91	12/31/91	1.2673	0.9839
100269	09/01/90	08/31/91	1.4127	0.9808
100273	09/01/90	08/31/91	1.1329	0.9769
100275	01/01/91	12/31/91	1.2911	0.9940
100278	10/01/90	09/30/91	0.6872	0.9294
110001	10/01/90	09/30/91	1.1509	0.9885
110002	01/01/91	12/31/91	1.1993	0.9810
110004	10/01/90	09/30/91	1.2328	0.9927
110005	01/01/91	12/31/91	1.3594	0.9566
110006	10/01/90	09/30/91	1.2862	0.9950
110007	08/01/90	08/31/91	1.3723	0.9975
110009	11/01/90	10/31/91	1.0799	0.9640
110010	09/01/90	08/31/91	1.9547	0.9982
110013	10/01/90	09/30/91	1.0005	0.9558
110014	08/01/90	07/31/91	1.0805	0.9728
110016	09/30/90	09/28/91	1.2461	0.9899
110018	01/01/91	12/31/91	1.1748	0.9588
110020	09/01/90	08/31/91	1.1551	0.9859
110023	01/01/91	12/31/91	1.2044	0.9538
110024	01/01/91	12/31/91	1.3827	0.9912
110025	10/01/90	09/30/91	1.2773	0.9875
110028	12/31/90	12/29/91	1.5625	0.9982
110029	10/01/90	09/30/91	1.3032	0.9906
110032	10/01/90	09/30/91	1.1204	0.9879
110033	08/01/90	07/31/91	1.3284	0.9889
110036	01/01/91	12/31/91	1.8297	0.9975
110037	01/01/91	12/31/91	1.0605	0.9816
110038	10/01/90	09/30/91	1.3245	0.9968
110044	10/01/90	09/30/91	1.1271	0.9706
110045	08/01/90	07/31/91	1.0130	0.9627
110046	11/01/90	10/31/91	1.1848	0.9710
110048	10/01/90	09/30/91	1.1293	0.9692
110049	10/01/90	09/30/91	1.0818	0.9618
110050	01/01/91	12/31/91	1.1083	0.9696
110059	10/01/90	09/30/91	1.3396	0.9660
110061	10/01/90	09/30/91	0.9793	0.9644
110063	12/01/90	11/30/91	1.0270	0.9718
110065	01/01/91	12/31/91	0.9794	0.9875
110070	11/01/90	10/31/91	0.9581	0.9335
110072	01/01/91	12/31/91	0.9904	0.9709
110073	08/01/90	07/31/91	1.2631	0.9611
110074	10/01/90	09/30/91	1.2570	0.9864
110075	10/01/90	09/30/91	1.2160	0.9822
110076	10/01/90	09/30/91	1.3581	0.9880
110078	09/01/90	08/31/91	1.5963	0.9979
110079	01/01/91	12/31/91	1.3224	0.9974
110080	10/01/90	09/30/91	1.0552	0.9945
110082	01/01/91	12/31/91	2.0553	0.9983
110083	01/01/91	12/31/91	1.5286	0.9991

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
110085	01/01/91	12/31/91	1.1694	0.9610
110086	09/01/90	08/31/91	1.0824	0.9691
110087	09/01/90	08/31/91	1.2606	0.9852
110088	01/01/91	12/31/91	0.8980	0.9302
110089	01/01/91	12/31/91	1.1196	0.9629
110091	10/01/90	09/30/91	1.2791	0.9731
110092	10/01/90	09/30/91	1.0652	0.9703
110095	10/01/90	09/30/91	1.3301	0.9757
110096	01/01/91	12/31/91	1.1422	0.9710
110097	01/01/91	12/31/91	1.0895	0.9714
110100	01/01/91	12/31/91	1.1062	0.9777
110105	10/01/90	09/30/91	1.1649	0.9824
110107	10/01/90	09/30/91	1.6085	0.9979
110111	10/01/90	09/30/91	1.1403	0.9872
110112	09/01/90	08/31/91	0.9201	0.9742
110114	10/01/90	09/30/91	1.1536	0.9706
110115	01/01/91	12/31/91	1.6217	0.9983
110118	10/01/90	09/30/91	1.0071	0.9467
110120	10/01/90	09/30/91	1.0366	0.9319
110121	10/01/90	09/30/91	1.1158	0.9747
110122	10/01/90	09/30/91	1.3221	0.9856
110123	10/01/90	09/30/91	0.8699	1.0000
110129	01/01/91	12/31/91	1.5724	0.9975
110130	12/01/90	11/30/91	0.9954	0.9630
110133	07/01/90	09/01/91	0.8836	0.9309
110140	08/01/90	12/31/91	0.8778	0.9621
110142	10/01/90	09/30/91	1.1108	0.9577
110144	10/01/90	09/30/91	1.2363	0.9642
110146	01/01/91	12/31/91	0.9191	0.9587
110149	07/01/90	10/31/91	1.1052	0.9749
110150	10/01/90	09/30/91	1.2278	0.9785
110161	10/01/90	10/31/91	1.2651	0.9897
110165	11/01/89	07/31/91	1.1638	0.9891
110166	10/01/90	09/30/91	1.3456	0.9867
110171	11/01/90	10/31/91	1.3287	0.9919
110172	10/01/90	09/30/91	1.1532	0.9881
110177	09/01/90	08/31/91	1.3965	0.9978
110179	01/01/91	12/31/91	1.2188	0.9766
110187	01/01/91	12/31/91	1.1241	0.9320
110189	01/01/91	12/31/91	1.1022	0.9613
110190	01/01/91	12/31/91	1.1202	0.9606
110192	09/01/90	08/31/91	1.3426	0.9877
110193	01/01/91	12/31/91	1.2226	0.9806
110195	10/01/90	09/30/91	1.0969	0.9744
110198	11/01/90	10/31/91	1.3260	0.9857
110200	10/01/90	09/30/91	1.7387	0.9962
110201	09/01/90	08/31/91	1.2647	0.9946
110203	10/01/90	09/30/91	1.0427	0.9762
120006	01/01/91	12/31/91	1.2132	0.9956
120011	01/01/91	12/31/91	1.2199	0.9946
120022	01/01/91	12/31/91	1.4828	0.9987
130001	12/01/90	11/30/91	1.0871	0.9691
130002	10/01/90	09/30/91	1.3148	0.9868
130005	01/01/91	12/31/91	1.3644	0.9920
130006	10/01/90	09/30/91	1.6766	0.9983
130009	10/01/90	09/30/91	0.9889	0.9438
130010	10/01/90	09/30/91	0.9302	0.9614
130011	01/01/91	12/31/91	1.3006	0.9801
130012	10/01/90	09/30/91	1.0122	0.9455
130014	10/01/90	09/30/91	1.2587	0.9800
130015	10/01/90	09/30/91	0.9981	0.9735
130018	10/01/90	09/30/91	1.5621	0.9993
130019	01/01/91	12/31/91	1.1630	0.9482
130021	12/01/90	11/30/91	0.9053	0.9299
130024	09/01/90	08/31/91	1.1126	0.9586
130025	10/01/90	09/30/91	1.0680	0.9806
130026	01/01/91	12/31/91	1.1236	0.9718
130027	10/01/90	09/30/91	0.8584	0.9564
130028	10/01/90	09/30/91	1.2874	0.9949
130030	10/01/90	09/30/91	0.9618	0.9785
130031	10/01/90	09/30/91	0.9623	0.9558
130034	10/01/90	09/30/91	0.9073	0.9614
130036	01/01/91	12/31/91	1.2010	0.9727
130037	10/01/90	09/30/91	1.4009	0.9633
130039	10/01/90	09/30/91	1.1602	0.9804
130040	10/01/90	09/30/91	1.0492	0.9931
130043	10/01/90	09/30/91	0.9815	0.9717

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
130044	10/01/90	09/30/91	0.9094	0.9480
130045	10/01/90	09/30/91	0.9224	0.9731
130049	12/01/90	11/30/91	1.1969	0.9861
130051	12/01/90	12/31/91	0.9918	0.9837
130054	10/01/90	09/30/91	0.9194	0.9712
130056	10/01/90	09/30/91	0.9862	0.9825
130058	10/01/89	08/31/91	0.9495	1.0000
140002	01/01/91	12/31/91	1.2404	0.9880
140004	10/01/90	09/30/91	0.9856	0.9624
140007	09/01/90	08/31/91	1.2563	0.9920
140008	01/01/91	12/31/91	1.4098	0.9956
140010	10/01/90	09/30/91	1.3500	0.9970
140012	01/01/91	12/31/91	1.2324	0.9868
140013	01/01/91	12/31/91	1.4145	0.9906
140015	10/01/90	09/30/91	1.2324	0.9913
140019	09/01/90	08/31/91	0.9152	0.9706
140029	01/01/91	12/31/91	1.3470	0.9933
140031	01/01/91	12/31/91	1.0586	0.9781
140033	09/01/90	08/31/91	1.2003	0.9921
140034	01/01/91	12/31/91	1.1101	0.9823
140036	10/01/90	09/30/91	1.1245	0.9648
140039	01/01/91	12/31/91	1.0066	0.9561
140046	01/01/91	12/31/91	1.2066	0.9696
140048	01/01/91	12/31/91	1.2186	0.9954
140049	11/01/90	10/31/91	1.3549	0.9974
140051	10/01/90	09/30/91	1.2992	0.9916
140052	01/01/91	12/31/91	1.1951	0.9856
140054	09/30/90	09/28/91	1.3516	0.9892
140058	10/01/90	09/30/91	1.0895	0.9881
140062	01/01/91	12/31/91	1.2520	0.9899
140063	01/01/91	12/31/91	1.3347	0.9948
140064	10/01/90	09/30/91	1.1583	0.9842
140065	01/01/91	12/31/91	1.3743	0.9960
140068	01/01/91	12/31/91	1.1913	0.9889
140067	10/01/90	09/30/91	1.7011	0.9989
140072	07/01/90	08/23/91	1.1304	0.9896
140074	10/01/90	09/30/91	1.1381	0.9389
140075	07/01/90	08/31/91	1.3840	0.9964
140079	01/01/91	12/31/91	1.2521	0.9926
140080	01/01/91	12/31/91	1.8474	0.9959
140084	01/01/91	12/31/91	1.1909	0.9910
140087	01/01/91	12/31/91	1.3704	0.9911
140090	01/01/91	12/31/91	1.3693	0.9978
140093	09/01/90	08/31/91	1.2451	0.9840
140094	01/01/91	12/31/91	1.2807	0.9888
140095	09/01/90	08/31/91	1.2502	0.9853
140097	01/01/91	12/31/91	0.8783	0.9668
140098	01/01/91	12/31/91	1.4170	0.9917
140101	12/01/90	11/30/91	1.0545	0.9762
140103	01/01/91	12/31/91	1.3556	0.9948
140105	01/01/91	12/31/91	1.2889	0.9843
140107	01/01/91	12/31/91	0.9246	0.9633
140108	01/01/91	12/31/91	1.1708	0.9890
140112	10/01/90	09/30/91	1.0460	0.9846
140113	01/01/91	12/31/91	1.4039	0.9979
140118	01/01/91	12/31/91	1.4717	0.9979
140122	01/01/91	12/31/91	1.3930	0.9942
140123	01/01/91	12/31/91	1.1980	0.9957
140124	12/03/90	12/01/91	1.1377	0.9985
140125	01/01/91	12/31/91	1.2510	0.9885
140128	10/01/90	09/30/91	1.1318	0.9591
140129	01/01/91	12/31/91	1.0440	0.9785
140130	01/01/91	12/31/91	1.1376	0.9951
140132	10/01/90	09/30/91	1.5682	0.9987
140135	10/01/90	09/30/91	1.2017	0.9897
140137	01/01/91	12/31/91	1.0057	0.9489
140139	10/01/90	09/30/91	1.0677	0.9590
140141	08/01/90	07/31/91	0.9738	0.9703
140143	10/01/90	09/30/91	1.0548	0.9783
140147	12/01/90	11/30/91	1.1928	0.9837
140148	10/01/90	09/30/91	1.5307	0.9988
140152	01/01/91	12/31/91	1.0219	0.9981
140154	09/01/90	08/31/91	1.2571	0.9877
140155	01/01/91	12/31/91	1.1878	0.9899
140160	08/01/90	07/31/91	1.1532	0.9854
140161	10/01/90	09/30/91	1.1287	0.9818
140162	10/01/90	09/30/91	1.4834	0.9886

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
140167	10/01/90	09/30/91	1.0723	0.9817
140176	10/01/90	09/30/91	1.2124	0.9838
140180	01/01/91	12/31/91	1.4230	0.9972
140181	01/01/91	12/31/91	1.2838	0.9941
140182	11/01/90	10/31/91	1.3137	0.9954
140185	01/01/91	12/31/91	1.3916	0.9889
140186	01/01/91	12/31/91	1.2096	0.9859
140188	09/01/90	08/31/91	0.9522	0.9316
140191	01/01/91	12/31/91	1.4306	0.9959
140192	10/01/90	09/30/91	1.1449	0.9906
140197	10/01/90	09/30/91	1.2887	0.9961
140202	01/01/91	12/31/91	1.2302	0.9905
140203	10/01/90	09/30/91	1.1259	0.9641
140206	10/01/90	09/30/91	1.0900	0.9962
140207	01/01/91	12/31/91	1.2960	0.9959
140208	01/01/91	12/31/91	1.4567	0.9979
140209	01/01/91	12/31/91	1.5995	0.9977
140211	09/01/90	08/31/91	1.1438	0.9893
140212	01/01/91	12/31/91	1.2629	0.9960
140217	09/01/90	08/31/91	1.2150	0.9931
140220	10/01/90	09/30/91	1.1310	0.9689
140226	10/01/90	09/30/91	0.9399	0.9937
140233	10/01/90	09/30/91	1.6558	0.9956
140236	10/01/90	09/30/91	0.9842	0.9918
140240	01/01/91	12/31/91	1.3118	0.9930
140252	11/01/90	10/31/91	1.2851	0.9879
140253	10/01/90	09/30/91	1.2956	0.9990
140258	01/01/91	12/31/91	1.4248	0.9925
140271	01/01/91	12/31/91	1.0489	0.9585
140281	09/01/90	08/31/91	1.5165	0.9984
140285	01/01/91	12/31/91	1.2715	0.9956
140288	01/01/91	12/31/91	1.5491	0.9970
140289	01/01/91	12/31/91	1.2683	0.9848
140290	09/01/90	08/31/91	1.3822	0.9926
140291	01/01/91	12/31/91	1.2727	0.9902
140292	01/01/91	12/31/91	1.1977	0.9719
140294	01/01/91	12/31/91	1.0800	0.9648
150001	01/01/91	12/31/91	1.0653	0.9794
150002	01/01/91	12/31/91	1.3296	0.9958
150003	01/01/91	12/31/91	1.6028	0.9957
150004	01/01/91	12/31/91	1.3222	0.9977
150005	01/01/91	12/31/91	1.2193	0.9802
150006	01/01/91	12/31/91	1.1986	0.9834
150007	01/01/91	12/31/91	1.1959	0.9828
150008	01/01/91	12/31/91	1.3371	0.9979
150009	01/01/91	12/31/91	1.2999	0.9940
150010	01/01/91	12/31/91	1.1878	0.9875
150013	01/01/91	12/31/91	1.2320	0.9744
150014	07/01/90	08/31/91	1.3260	0.9910
150015	01/01/91	12/31/91	1.2376	0.9932
150017	01/01/91	12/31/91	1.6696	0.9996
150018	01/01/91	12/31/91	1.2651	0.9839
150020	10/01/90	09/30/91	1.1241	0.9952
150021	01/01/91	12/31/91	1.6160	0.9984
150022	01/01/91	12/31/91	1.1214	0.9796
150023	09/01/90	08/31/91	1.3740	0.9969
150024	01/01/91	12/31/91	1.1993	0.9927
150026	01/01/91	12/31/91	1.1750	0.9816
150027	01/01/91	12/31/91	1.0046	0.9620
150029	01/01/91	12/31/91	1.2490	0.9868
150030	01/01/91	12/31/91	1.1425	0.9859
150031	10/01/90	09/30/91	1.0721	0.9690
150033	01/01/91	12/31/91	1.5659	0.9983
150034	01/01/91	12/31/91	1.3172	0.9971
150035	01/01/91	12/31/91	1.4009	0.9975
150036	01/01/91	12/31/91	1.0322	0.9822
150037	01/01/91	12/31/91	1.2001	0.9815
150038	01/01/91	12/31/91	1.2252	0.9749
150039	10/01/90	09/30/91	0.9885	0.9598
150042	01/01/91	12/31/91	1.1896	0.9912
150044	01/01/91	12/31/91	1.2335	0.9914
150045	10/01/90	09/30/91	1.1584	0.9788
150046	05/01/90	08/31/91	1.4191	0.9968
150047	01/01/91	12/31/91	1.6844	0.9996
150048	01/01/91	12/31/91	1.1919	0.9864
150049	01/01/91	12/31/91	1.1042	0.9861
150050	01/01/91	12/31/91	1.1569	0.9617

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
150051	10/01/90	09/30/91	1.2461	0.9911
150052	01/01/91	12/31/91	1.0397	0.9607
150053	01/01/91	12/31/91	1.0269	0.9726
150054	01/01/91	12/31/91	1.0263	0.9807
150057	01/01/91	12/31/91	2.1621	0.9875
150058	01/01/91	12/31/91	1.5511	0.9973
150059	01/01/91	12/31/91	1.2267	0.9844
150060	01/01/91	12/31/91	1.1650	0.9672
150061	01/01/91	12/31/91	1.1894	0.9871
150062	01/01/91	12/31/91	1.0766	0.9746
150063	01/01/91	12/31/91	1.1477	0.9765
150064	10/01/90	09/30/91	1.0560	0.9737
150065	01/01/91	12/31/91	1.1029	0.9774
150066	01/01/91	12/31/91	1.1404	0.9719
150067	01/01/91	12/31/91	1.1103	0.9617
150069	01/01/91	12/31/91	1.2483	0.9783
150070	01/01/91	12/31/91	1.0849	0.9342
150071	01/01/91	12/31/91	1.1399	0.9543
150072	01/01/91	12/31/91	1.2786	0.9815
150073	01/01/91	12/31/91	1.0474	0.9649
150074	10/01/90	09/30/91	1.4864	0.9996
150075	10/01/90	09/30/91	1.2383	0.9917
150078	01/01/91	12/31/91	1.0664	0.9879
150079	10/01/90	09/30/91	1.1550	0.9815
150086	01/01/91	12/31/91	1.2567	0.9810
150090	07/01/90	12/31/91	1.2784	0.8864
150091	01/01/91	12/31/91	1.1941	0.9563
150092	01/01/91	12/31/91	1.1163	0.9291
150094	01/01/91	12/31/91	1.0335	0.9701
150095	10/01/90	09/30/91	1.1065	0.9702
150096	01/01/91	12/31/91	1.0522	0.9538
150097	01/01/91	12/31/91	1.0378	0.9702
150098	01/01/91	12/31/91	1.0456	0.9411
150101	01/01/91	12/31/91	1.0838	0.9534
150102	01/01/91	12/31/91	1.0877	0.9638
150104	01/01/91	12/31/91	1.1697	0.9670
150105	01/01/91	12/31/91	1.1936	0.9764
150106	01/01/91	12/31/91	1.0776	0.9536
150109	01/01/91	12/31/91	1.2844	0.9951
150111	01/01/91	12/31/91	1.0875	0.9678
150112	01/01/91	12/31/91	1.1913	0.9871
150113	01/01/91	12/31/91	1.2430	0.9813
150114	01/01/91	12/31/91	1.0742	0.9455
150122	01/01/91	12/31/91	1.0842	0.9371
150123	08/01/90	07/31/91	0.9589	0.9854
150124	10/01/90	09/30/91	1.1830	0.9802
150127	10/01/90	09/30/91	1.1323	0.9363
150128	10/01/90	09/30/91	1.1876	0.9963
150129	09/01/90	08/31/91	1.2691	0.9878
150132	01/01/91	12/31/91	1.3798	0.9980
150133	01/01/91	12/31/91	1.2262	0.9709
150134	09/01/90	08/31/91	1.1485	0.9813
150136	09/01/90	08/31/91	1.0882	1.0000
160001	11/01/90	10/31/91	1.1504	0.9785
160002	10/01/90	09/30/91	1.2315	0.9698
160003	01/01/91	12/31/91	1.0415	0.9751
160008	10/01/90	09/30/91	1.0831	0.9758
160024	01/01/91	12/31/91	1.4475	0.9984
160044	01/01/91	12/31/91	1.2670	0.9649
160045	09/01/90	08/31/91	1.6143	0.9983
160047	10/01/90	09/30/91	1.4141	0.9910
160051	10/01/90	09/30/91	1.3118	0.9486
160071	01/01/91	12/31/91	1.1043	0.9527
160072	01/01/91	12/31/91	1.0534	0.9752
160082	08/01/90	07/31/91	1.6609	0.9980
160092	01/01/91	12/31/91	0.9405	0.9546
160099	10/01/90	09/30/91	1.1015	0.9657
160104	12/01/90	11/30/91	1.1248	0.9881
160110	01/01/91	12/31/91	1.5254	0.9952
160111	09/01/90	08/31/91	1.1404	0.9713
160119	07/01/90	06/30/91	0.8411	0.9534
160122	10/01/90	09/30/91	1.2221	0.9619
160129	01/01/91	12/31/91	1.1463	0.9625
160130	10/01/90	09/30/91	1.2440	0.9905
160131	01/01/91	12/31/91	1.1389	0.9879
160133	01/01/91	12/31/91	1.2545	0.9834
160138	01/01/91	12/31/91	1.2621	0.9668

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
160147	01/01/91	12/31/91	1.1959	0.9747
170001	01/01/91	12/31/91	1.1871	0.9801
170004	01/01/91	12/31/91	1.0666	0.9702
170006	10/01/90	09/30/91	1.2445	0.9904
170008	09/01/90	08/31/91	0.9737	0.9690
170012	10/01/90	09/30/91	1.4313	0.9815
170014	01/01/91	12/31/91	1.0799	0.9543
170017	01/01/91	12/31/91	1.1914	0.9781
170018	01/01/91	12/31/91	1.0790	0.9614
170019	01/01/91	12/31/91	1.1816	0.9778
170021	01/01/90	08/31/91	0.9124	0.9767
170022	10/01/90	09/30/91	1.1870	0.9699
170023	01/01/91	12/31/91	1.3268	0.9880
170024	10/01/90	09/30/91	1.1094	0.9948
170026	10/01/90	09/30/91	0.9880	0.9790
170027	10/01/90	09/30/91	1.1657	0.9621
170030	01/01/91	12/31/91	0.9619	0.9198
170031	01/01/91	12/31/91	0.8845	0.9873
170032	10/01/90	09/30/91	1.0483	0.9672
170033	01/01/91	12/31/91	1.2181	0.9753
170034	01/01/91	12/31/91	0.9467	0.9886
170035	10/01/90	09/30/91	0.8666	0.8963
170036	01/01/91	12/31/91	0.9163	0.9737
170038	01/01/91	12/31/91	1.0021	0.9573
170039	01/01/91	12/31/91	1.0813	0.9645
170041	01/01/91	12/31/91	1.0285	0.9599
170043	01/01/91	12/31/91	1.0836	0.9541
170049	01/01/91	12/31/91	1.2901	0.9865
170050	01/01/91	12/31/91	1.0298	0.9253
170054	01/01/91	12/31/91	1.0964	0.9768
170055	01/01/91	12/31/91	1.0824	0.9788
170060	01/01/91	12/31/91	1.0253	0.9784
170062	10/01/90	09/30/91	0.8355	0.9748
170063	01/01/91	12/31/91	0.9246	0.9233
170064	01/01/91	12/31/91	1.2035	0.9613
170066	01/01/91	12/31/91	0.9297	0.9297
170068	01/01/91	12/31/91	1.2806	0.9775
170070	01/01/91	12/31/91	1.0607	0.9643
170073	01/01/91	12/31/91	1.1376	0.9694
170075	10/01/90	09/30/91	0.8523	0.9754
170076	01/01/91	12/31/91	1.0856	0.9984
170077	01/01/91	12/31/91	0.9483	0.9633
170079	01/01/91	12/31/91	0.9515	0.9101
170080	01/01/91	12/31/91	0.9663	0.9673
170081	01/01/91	12/31/91	1.1453	0.9790
170082	01/01/91	12/31/91	0.9336	0.9815
170086	10/01/90	09/30/91	1.6362	0.9989
170087	10/01/90	09/30/91	1.3417	0.9985
170088	01/01/91	12/31/91	0.9132	0.9387
170090	01/01/91	12/31/91	0.9873	0.9473
170092	01/01/91	12/31/91	0.8454	0.9291
170094	01/01/91	12/31/91	1.0792	0.9475
170097	01/01/91	12/31/91	0.9314	0.9595
170098	01/01/91	12/31/91	1.0584	0.9855
170099	01/01/91	12/31/91	1.3736	1.0000
170101	10/01/90	09/30/91	0.9966	0.9746
170102	01/01/91	12/31/91	0.9843	0.9478
170104	01/01/91	12/31/91	1.4312	0.9972
170106	09/01/90	08/31/91	0.8840	0.9261
170108	01/01/91	12/31/91	0.9255	0.9134
170109	01/01/91	12/31/91	1.0164	0.9400
170110	01/01/91	12/31/91	0.9366	0.9712
170112	01/01/91	12/31/91	0.9089	0.9810
170113	01/01/91	12/31/91	1.0569	0.9695
170114	01/01/91	12/31/91	1.0517	0.9601
170116	01/01/91	12/31/91	1.1438	0.9398
170117	01/01/91	12/31/91	0.9797	0.9836
170119	01/01/91	12/31/91	0.9921	0.9422
170120	01/01/91	12/31/91	1.2404	0.9663
170121	01/01/91	12/31/91	0.7783	0.9407
170122	10/01/90	09/30/91	1.7991	0.9982
170123	01/01/91	12/31/91	1.6703	0.9978
170124	01/01/91	12/31/91	0.9567	0.9512
170126	10/01/90	09/30/91	0.9325	0.9729
170128	01/01/91	12/31/91	0.9678	0.9153
170131	01/01/91	12/31/91	1.1317	0.9660
170134	01/01/91	12/31/91	0.9780	0.9807

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
170137	01/01/91	12/31/91	1.1353	0.9796
170139	01/01/91	12/31/91	1.0304	0.9662
170143	01/01/91	12/31/91	1.1006	0.9487
170144	10/01/90	09/30/91	1.4929	0.9929
170145	01/01/91	12/31/91	1.1522	0.9898
170146	01/01/91	12/31/91	1.2837	0.9986
170147	10/01/90	09/30/91	1.2052	0.9801
170148	10/01/90	09/30/91	1.3403	0.9973
170150	01/01/91	12/31/91	1.1231	0.9535
170151	01/01/91	12/31/91	1.0189	0.9438
170152	01/01/91	12/31/91	0.9367	0.9567
170160	01/01/91	12/31/91	0.9708	0.9535
170164	01/01/91	12/31/91	1.0513	0.9765
170166	01/01/91	12/31/91	0.9869	0.9879
170168	01/01/91	12/31/91	0.9263	0.9585
170170	01/01/90	10/31/91	0.9068	0.9624
170173	01/01/90	10/25/91	0.8782	0.8674
170174	01/01/91	12/31/91	0.9475	0.9086
170175	09/01/90	08/31/91	1.2204	0.9777
170176	09/01/90	08/31/91	1.4214	0.9966
180001	01/01/91	12/31/91	1.1806	0.9956
180004	10/01/90	09/30/91	1.1858	0.9737
180009	10/01/90	09/30/91	1.1718	0.9960
180010	09/01/90	08/31/91	1.7046	0.9995
180011	09/01/90	08/31/91	1.1240	0.9744
180014	09/01/90	08/31/91	1.5630	0.9993
180015	01/01/91	12/31/91	1.1145	0.9921
180016	01/01/91	12/31/91	1.2556	0.9785
180017	10/01/90	09/30/91	1.2195	0.9927
180019	12/01/90	11/30/91	1.1725	0.9766
180023	10/01/90	09/30/91	0.8333	0.9770
180025	09/01/90	08/31/91	1.1348	0.9718
180026	01/01/91	12/31/91	1.1060	0.9641
180030	10/01/90	09/30/91	1.1471	0.9837
180031	10/01/90	09/30/91	1.0060	0.9930
180035	01/01/91	12/31/91	1.4445	0.9990
180036	01/01/91	12/31/91	1.1007	0.9907
180037	09/01/90	08/31/91	1.2798	0.9918
180040	01/01/91	12/31/91	1.9836	0.9993
180041	10/01/90	09/30/91	1.0810	0.9650
180043	10/01/90	09/30/91	1.0062	0.9469
180044	10/01/90	09/30/91	1.0789	0.9811
180045	01/01/91	12/31/91	1.1768	0.9916
180048	10/01/90	09/30/91	1.2056	0.9829
180051	12/01/90	11/30/91	1.2023	0.9864
180058	01/01/91	12/31/91	0.8913	0.9411
180059	01/01/91	12/31/91	0.9118	0.9514
180060	01/01/91	12/31/91	0.8573	1.0000
180062	07/01/90	09/04/91	0.8121	0.9456
180063	10/01/90	09/30/91	1.0327	0.9833
180064	10/01/90	09/30/91	1.0597	0.9753
180066	11/01/90	10/31/91	1.1757	0.9559
180072	10/01/90	09/30/91	1.0925	0.9667
180078	10/01/90	09/30/91	1.0086	0.9846
180079	10/01/90	09/30/91	1.0186	0.9828
180080	09/01/90	08/31/91	1.1375	0.9782
180081	01/01/91	12/31/91	1.4039	0.9980
180085	01/01/91	12/31/91	1.3268	0.9945
180088	01/01/91	12/31/91	1.6584	0.9996
180094	01/01/91	12/31/91	1.0093	0.9713
180095	10/01/90	09/30/91	0.9768	0.9753
180099	10/01/90	09/30/91	0.9662	0.9675
180102	01/01/91	12/31/91	1.4138	0.9967
180103	09/01/90	08/31/91	1.7691	0.9976
180104	09/01/90	08/31/91	1.4002	0.9990
180106	09/01/90	08/31/91	0.8949	0.9598
180115	11/01/90	10/31/91	0.9694	0.9642
180116	09/01/90	08/31/91	1.2810	0.9827
180120	01/01/91	12/31/91	0.8883	0.9658
180121	01/01/91	12/31/91	1.0603	0.9605
180123	09/01/90	08/31/91	1.4452	0.9957
180124	10/01/90	09/30/91	1.3297	0.9958
180126	11/01/90	10/31/91	1.0408	0.9512
180127	08/01/90	07/31/91	1.1495	0.9720
180128	09/01/90	08/31/91	1.1173	0.9816
180130	09/01/90	08/31/91	1.3783	0.9961
180132	09/01/90	08/31/91	1.3109	0.9844

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
180133.....	09/01/90	08/31/91	1.2193	0.9888
180136.....	09/01/90	08/31/91	1.2780	0.9906
180137.....	09/01/90	08/31/91	1.7639	0.9963
180138.....	01/01/91	12/31/91	1.2505	0.9877
190002.....	10/01/90	09/30/91	1.5780	0.9983
190003.....	09/01/90	08/31/91	1.3715	0.9770
190004.....	10/01/90	09/30/91	1.1510	0.9802
190013.....	01/01/91	12/31/91	1.1919	0.9812
190018.....	10/01/90	09/30/91	1.1615	0.9779
190025.....	10/01/90	09/30/91	1.2542	0.9922
190026.....	10/01/90	09/30/91	1.3170	0.9978
190034.....	01/01/91	12/31/91	1.2138	0.9826
190039.....	01/01/91	12/31/91	1.4427	0.9989
190040.....	10/01/90	09/30/91	1.3627	0.9963
190043.....	01/01/91	12/31/91	1.0782	0.9816
190044.....	10/01/90	09/30/91	1.0913	0.9808
190046.....	01/01/91	12/31/91	1.3967	0.9984
190049.....	01/01/91	12/31/91	0.9612	0.9649
190050.....	11/01/90	10/31/91	1.0344	0.9708
190053.....	12/01/90	11/30/91	1.0246	0.9590
190054.....	07/01/90	09/30/91	1.3816	0.9809
190059.....	11/01/90	10/31/91	0.9408	0.9692
190060.....	01/01/91	12/31/91	1.2396	0.9934
190064.....	01/01/91	12/31/91	1.4544	0.9991
190065.....	10/01/90	09/30/91	1.4556	0.9981
190077.....	01/01/91	12/31/91	0.9049	0.9841
190078.....	01/01/91	12/31/91	1.1399	0.9769
190083.....	10/01/90	09/30/91	0.8837	0.9647
190088.....	09/01/90	08/31/91	1.3234	0.9780
190089.....	10/01/90	09/30/91	1.0606	0.9754
190090.....	09/01/90	08/31/91	1.1983	0.9703
190092.....	01/01/91	12/31/91	1.1950	0.9922
190095.....	10/01/90	09/30/91	1.0355	0.9764
190099.....	09/01/90	08/31/91	1.1890	0.9593
190102.....	10/01/90	09/30/91	1.4398	0.9986
190106.....	09/01/90	08/31/91	1.1604	0.9819
190109.....	10/01/90	09/30/91	1.0960	0.9760
190110.....	10/01/90	09/30/91	0.9634	0.9731
190111.....	10/01/90	09/30/91	1.5684	0.9989
190113.....	01/01/91	12/31/91	1.2906	0.9963
190115.....	01/01/91	12/31/91	1.2852	0.9943
190116.....	01/01/91	12/31/91	1.2168	0.9911
190118.....	10/01/90	09/30/91	0.9912	0.9673
190120.....	09/01/90	08/31/91	0.8938	0.9106
190125.....	10/01/90	09/30/91	1.3917	0.9978
190127.....	10/01/90	09/30/91	1.4583	0.9969
190128.....	10/01/90	09/30/91	0.8293	0.9981
190130.....	10/01/90	09/30/91	0.9182	0.9712
190134.....	10/01/90	09/30/91	1.0004	0.9650
190135.....	10/01/90	09/30/91	1.3431	0.9979
190136.....	10/01/90	09/30/91	1.0323	0.9753
190142.....	11/01/90	10/31/91	0.9442	0.9684
190144.....	09/01/90	08/31/91	1.1496	0.9736
190145.....	10/01/90	09/30/91	0.9274	0.9922
190146.....	01/01/91	12/31/91	1.4728	0.9984
190147.....	10/01/90	09/30/91	0.9570	0.9589
190149.....	10/01/90	09/30/91	0.9803	0.9738
190151.....	10/01/90	09/30/91	1.0824	0.9899
190160.....	09/01/90	08/31/91	1.1126	0.9965
190162.....	01/01/91	12/31/91	1.3001	0.9978
190164.....	01/01/91	12/31/91	1.0557	0.9858
190167.....	09/01/90	08/31/91	1.2898	0.9844
190175.....	01/01/91	12/31/91	1.1239	0.8571
190177.....	01/01/91	12/31/91	1.4642	0.9919
190178.....	09/01/90	08/31/91	0.9728	0.9639
190184.....	10/01/90	09/30/91	0.8960	0.9796
190185.....	01/01/91	12/31/91	1.2192	0.9961
190186.....	10/01/90	09/30/91	0.9519	0.9799
190189.....	01/01/91	12/31/91	1.1090	0.9321
190190.....	04/01/90	12/31/91	0.9948	0.9764
190191.....	01/01/91	12/31/91	1.2447	0.9805
190193.....	01/01/91	12/31/91	1.1975	0.9841
190194.....	10/01/90	09/30/91	1.1301	0.9763
190197.....	01/01/91	12/31/91	1.2036	0.9918
190198.....	09/01/90	08/31/91	1.1923	0.9894
190200.....	09/01/90	08/31/91	1.5966	0.9989
190201.....	09/01/90	08/31/91	1.2137	0.9837

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
190202	09/01/90	08/31/91	1.4228	0.9969
190203	01/01/91	12/31/91	1.6042	1.0000
190205	09/01/90	08/31/91	1.3354	0.9938
190208	09/01/90	08/31/91	1.4352	0.9978
190207	09/01/90	08/31/91	1.2129	0.9797
190208	01/01/91	12/31/91	0.8820	0.9295
190211	01/01/91	12/31/91	0.5007	1.0000
190212	01/01/91	12/31/91	0.9109	1.0000
200001	01/01/91	12/31/91	1.3139	0.9932
200006	10/01/90	09/30/91	1.0647	0.9657
200007	11/01/90	10/31/91	1.0291	0.9794
200009	10/01/90	09/30/91	1.6652	0.9981
200017	09/01/90	08/31/91	1.3031	0.9916
200018	01/01/91	12/31/91	1.1075	0.9829
200021	10/01/90	09/30/91	1.1342	0.9783
200025	01/01/91	12/31/91	1.1802	0.9929
200026	10/01/90	09/30/91	0.9954	0.9857
200027	01/01/91	12/31/91	1.1128	0.9724
200028	12/01/90	11/30/91	1.0183	0.9850
200031	01/01/91	12/31/91	1.2773	0.9933
200032	01/01/91	12/31/91	1.3002	0.9775
200033	09/30/90	09/28/91	1.6828	0.9968
200034	01/01/91	12/31/91	1.1762	0.9913
200041	01/01/91	12/31/91	1.1606	0.9863
200043	01/01/91	12/31/91	0.6497	0.9527
200044	10/01/90	09/30/91	1.1539	0.9906
200052	10/01/90	09/30/91	1.0225	0.9891
200055	01/01/91	12/31/91	1.0381	0.9703
200062	01/01/91	12/31/91	0.9859	0.9729
200066	10/01/90	09/30/91	1.1383	0.9816
210006	01/01/91	12/31/91	1.0833	0.9921
210011	01/01/91	12/31/91	1.2911	0.9941
210046	07/01/90	11/26/91	1.1206	0.9866
210049	01/01/91	12/31/91	1.1617	0.9880
220001	10/01/90	09/30/91	1.1452	0.9899
220002	10/01/90	09/30/91	1.3390	0.9985
220003	10/01/90	09/30/91	1.1005	0.9781
220004	10/01/90	09/30/91	1.3480	0.9899
220006	10/01/90	09/30/91	1.2643	0.9935
220008	10/01/90	09/30/91	1.1499	0.9878
220010	10/01/90	09/30/91	1.2007	0.9903
220012	10/01/90	09/30/91	1.1816	0.9792
220015	10/01/90	09/30/91	1.2005	0.9920
220017	10/01/90	09/30/91	1.1896	0.9838
220019	10/01/90	09/30/91	1.2507	0.9938
220020	10/01/90	09/30/91	1.0950	0.9867
220021	10/01/90	09/30/91	1.1518	0.9888
220023	10/01/90	09/30/91	1.2296	0.9918
220024	10/01/90	09/30/91	1.2617	0.9937
220025	10/01/90	09/30/91	1.1935	0.9913
220026	10/01/90	09/30/91	1.0234	0.9836
220028	10/01/90	09/30/91	1.2712	0.9944
220029	10/01/90	09/30/91	1.4016	0.9983
220030	10/01/90	09/30/91	1.1155	0.9854
220031	10/01/90	09/30/91	1.0736	0.9802
220031	09/30/90	09/28/91	1.7788	0.9975
220033	10/01/90	09/30/91	1.2330	0.9953
220035	10/01/90	09/30/91	1.1784	0.9948
220036	10/01/90	09/30/91	1.4854	0.9978
220038	10/01/90	09/30/91	1.2641	0.9801
220042	10/01/90	09/30/91	1.1604	0.9880
220045	10/01/90	09/30/91	1.1920	0.9880
220046	10/01/90	09/30/91	1.3652	0.9957
220048	10/01/90	09/30/91	1.1728	0.9928
220049	10/01/90	09/30/91	1.1794	0.9844
220050	10/01/90	09/30/91	0.9903	0.9790
220051	10/01/90	09/30/91	1.2256	0.9880
220052	10/01/90	09/30/91	1.2316	0.9895
220053	10/01/90	09/30/91	1.2756	0.9961
220055	10/01/90	09/30/91	1.1782	0.9920
220057	10/01/90	09/30/91	1.1955	0.9932
220058	10/01/90	09/30/91	1.0048	0.9722
220060	10/01/90	09/30/91	1.1391	0.9944
220062	10/01/90	09/30/91	0.6543	0.9618
220063	10/01/90	09/30/91	1.1276	0.9908
220064	10/01/90	09/30/91	1.1817	0.9852
220065	10/01/90	09/30/91	1.1739	0.9829

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
220066	10/01/90	09/30/91	1.2842	0.9964
220067	10/01/90	09/30/91	1.2425	0.9901
220068	10/01/90	09/30/91	0.6150	0.9916
220070	10/01/90	09/30/91	1.1438	0.9906
220071	10/01/90	09/30/91	1.8445	0.9973
220073	10/01/90	09/30/91	1.2258	0.9930
220074	10/01/90	09/30/91	1.1346	0.9750
220075	10/01/90	09/30/91	0.7565	0.9901
220076	10/01/90	09/30/91	1.1981	0.9872
220077	10/01/90	09/30/91	1.6054	0.9977
220079	10/01/90	09/30/91	1.1169	0.9928
220080	10/01/90	09/30/91	1.1952	0.9926
220081	10/01/90	09/30/91	0.9596	0.9603
220082	10/01/90	09/30/91	1.2244	0.9933
220084	10/01/90	09/30/91	1.1440	0.9686
220086	09/30/90	09/28/91	1.5565	0.9984
220088	10/01/90	09/30/91	1.4871	0.9923
220089	10/01/90	09/30/91	1.2772	0.9902
220090	10/01/90	09/30/91	1.1730	0.9897
220092	10/01/90	09/30/91	1.1913	0.9878
220094	10/01/90	09/30/91	1.2034	0.9901
220095	10/01/90	09/30/91	1.1870	0.9815
220097	10/01/90	09/30/91	1.0106	0.9943
220098	10/01/90	09/30/91	1.2848	0.9779
220099	10/01/90	09/30/91	1.1372	0.9878
220100	10/01/90	09/30/91	1.2696	0.9911
220101	10/01/90	09/30/91	1.3759	0.9920
220102	10/01/90	09/30/91	0.8471	1.0000
220104	10/01/90	09/30/91	1.2536	0.9892
220105	10/01/90	09/30/91	1.1748	0.9877
220106	10/01/90	09/30/91	1.1095	0.9859
220107	10/01/90	09/30/91	1.1494	0.9923
220108	10/01/90	09/30/91	1.1414	0.9902
220110	10/01/90	09/30/91	1.9210	0.9958
220111	10/01/90	09/30/91	1.1783	0.9760
220115	07/01/90	12/05/91	1.2749	0.9913
220116	09/30/90	09/28/91	1.7804	0.9962
220118	10/01/90	09/30/91	1.9208	0.9966
220119	10/01/90	09/30/91	1.3499	0.9883
220120	10/01/90	09/30/91	0.9903	0.9958
220123	10/01/90	09/30/91	0.9499	0.9613
220126	10/01/90	09/30/91	1.2248	0.9767
220128	10/01/90	09/30/91	1.1026	0.9884
220135	10/01/90	09/30/91	1.1185	0.9801
220156	10/01/90	09/30/91	1.2157	0.9871
220162	10/01/90	09/30/91	1.4238	0.7980
220171	10/01/90	09/30/91	1.6225	0.9973
220173	01/01/91	12/31/91	0.5125	1.0000
230003	10/01/90	09/30/91	1.1367	0.9882
230007	01/01/91	12/31/91	1.0879	0.9749
230012	01/01/91	12/31/91	0.8616	0.9919
230013	01/01/91	12/31/91	1.2956	0.9937
230014	04/01/90	12/31/91	0.9522	0.9625
230015	01/01/91	12/31/91	1.4123	0.9841
230017	01/01/91	12/31/91	1.5371	0.9970
230020	01/01/91	12/31/91	1.5989	0.9983
230021	10/01/90	09/30/91	1.5244	0.9973
230022	01/01/91	12/31/91	1.2727	0.9766
230040	10/01/90	09/30/91	1.3122	0.9800
230042	01/01/91	12/31/91	1.1196	0.9908
230053	01/01/91	12/31/91	1.4426	0.9992
230055	01/01/91	12/31/91	1.1107	0.9966
230056	10/01/90	09/30/91	0.9722	0.9609
230063	01/01/91	12/31/91	1.2719	0.9941
230065	01/01/91	12/31/91	1.4319	0.9950
230071	11/01/90	10/31/91	0.6457	1.0000
230076	01/01/91	12/31/91	1.2358	0.9982
230078	10/01/90	09/30/91	1.3192	0.9797
230080	10/01/90	09/30/91	1.2339	0.9835
230087	01/01/91	12/31/91	1.1456	0.9747
230089	09/01/90	08/31/91	1.3523	0.9961
230090	01/01/91	12/31/91	1.1740	0.9757
230096	10/01/90	09/30/91	1.0955	0.9843
230101	10/01/90	09/30/91	1.0478	0.9644
230103	01/01/91	12/31/91	1.0166	0.9687
230105	01/01/91	12/31/91	1.5115	0.9984
230107	01/01/91	12/31/91	0.9771	0.9704

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
230110	10/01/90	09/30/91	1.2243	0.9884
230114	01/01/91	12/31/91	0.7160	1.0000
230115	01/01/91	12/31/91	1.0103	0.9633
230118	10/01/90	09/30/91	1.2660	0.9740
230119	10/01/90	09/30/91	1.2023	0.9900
230121	01/01/91	12/31/91	1.2257	0.9814
230122	10/01/90	09/30/91	1.3557	0.9921
230125	10/01/90	09/30/91	1.3903	0.9822
230128	01/01/91	12/31/91	1.3727	0.9956
230129	01/01/91	12/31/91	1.9116	0.9973
230130	01/01/91	12/31/91	1.5889	0.9992
230134	01/01/91	12/31/91	1.2774	0.9873
230135	01/01/91	12/31/91	1.3010	0.9915
230137	10/01/90	09/30/91	1.0719	0.9841
230138	01/01/91	12/31/91	0.9051	0.9947
230141	10/01/90	09/30/91	1.5223	0.9980
230143	01/01/91	12/31/91	1.2210	0.9764
230144	07/01/90	12/31/91	1.1934	0.9932
230145	10/01/90	09/30/91	1.1114	0.9566
230146	01/01/91	12/31/91	1.2487	0.9875
230149	01/01/91	12/31/91	1.1197	0.9732
230150	10/01/90	09/30/91	1.5916	0.9976
230151	01/01/91	12/31/91	1.3942	0.9825
230155	01/01/91	12/31/91	1.0618	0.9634
230165	06/24/90	07/06/91	1.6982	0.9991
230167	01/01/91	12/31/91	1.1868	0.9945
230169	10/01/90	09/30/91	1.3223	0.9896
230171	01/01/91	12/31/91	1.1133	0.9641
230175	10/01/90	09/30/91	1.0144	0.9491
230184	10/01/90	09/30/91	1.1428	0.9880
230186	01/01/91	12/31/91	1.0063	0.9736
230190	01/01/91	12/31/91	0.9708	0.9554
230191	01/01/91	12/31/91	0.9232	0.9584
230193	01/01/91	12/31/91	1.2926	0.9924
230194	01/01/91	12/31/91	1.1699	0.9782
230195	10/01/90	09/30/91	1.3657	0.9870
230197	10/01/90	09/30/91	1.2315	0.9949
230204	10/01/90	09/30/91	1.2508	0.9944
230205	10/01/90	09/30/91	1.1162	0.9480
230208	01/01/91	12/31/91	1.0606	0.9787
230211	01/01/91	12/31/91	0.9233	0.9441
230213	01/01/91	12/31/91	1.0931	0.9656
230216	01/01/91	12/31/91	1.3052	0.9837
230217	01/01/91	12/31/91	1.1050	0.9767
230223	01/01/91	12/31/91	1.2866	0.9935
230227	01/01/91	12/31/91	1.3578	0.9968
230228	01/01/91	12/31/91	1.2029	0.9931
230230	01/01/91	12/31/91	1.3538	0.9886
230235	01/01/91	12/31/91	0.9915	0.9863
230236	10/01/90	09/30/91	1.3398	0.9972
230237	10/01/90	09/30/91	1.0876	0.9969
230239	10/01/90	09/30/91	1.1530	0.9767
230244	10/01/90	09/30/91	1.3711	0.9871
230253	10/01/90	09/30/91	1.1027	0.9619
230254	01/01/91	12/31/91	1.2664	0.9925
230257	06/24/90	07/06/91	0.8611	0.9601
230259	01/01/91	12/31/91	1.0923	0.9812
230266	10/01/90	09/30/91	1.2935	0.9830
230269	01/01/91	12/31/91	1.2294	0.9945
230273	01/01/91	12/31/91	1.5122	0.9960
230275	01/01/91	12/31/91	0.9074	1.0000
230276	01/01/91	12/31/91	1.0482	0.9893
230277	01/01/91	12/31/91	1.1543	0.9684
240001	01/01/91	12/31/91	1.5241	0.9968
240003	09/01/90	08/31/91	1.2481	0.9794
240004	01/01/91	12/31/91	1.4824	0.9795
240006	01/01/91	12/31/91	1.1396	0.9751
240007	10/01/90	09/30/91	1.1066	0.9705
240008	10/01/90	09/30/91	1.0283	0.9614
240010	01/01/91	12/31/91	1.8606	0.9947
240011	10/01/90	09/30/91	1.0342	0.9877
240013	10/01/90	09/30/91	1.2272	0.9757
240014	01/01/91	12/31/91	1.1829	0.9734
240016	10/01/90	09/30/91	1.3550	0.9870
240018	01/01/90	09/30/91	1.2384	0.9729
240019	01/01/91	12/31/91	1.3374	0.9989
240020	10/01/90	09/30/91	1.2248	0.9624

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
240021	10/01/90	09/30/91	1.0259	0.9499
240022	01/01/91	12/31/91	1.1065	0.9653
240023	01/01/91	12/31/91	1.0495	0.9514
240025	01/01/91	12/31/91	1.2071	0.9746
240027	10/01/90	09/30/91	1.0615	0.9713
240028	10/01/90	09/30/91	1.1175	0.9705
240029	10/01/90	09/30/91	1.1760	0.9798
240030	01/01/91	12/31/91	1.3259	0.9842
240031	01/01/91	12/31/91	0.9270	0.9572
240038	01/01/91	12/31/91	1.4546	0.9985
240041	10/01/90	09/30/91	1.2216	0.9972
240043	01/01/91	12/31/91	1.1400	0.9751
240045	10/01/90	09/30/91	1.1153	0.9494
240047	01/01/91	12/31/91	1.3942	0.9932
240048	09/01/90	08/31/91	1.2606	0.9891
240050	09/01/90	08/31/91	1.1107	0.9767
240051	10/01/90	09/30/91	0.8744	0.9292
240052	10/01/90	09/30/91	1.2223	0.9832
240056	01/01/91	12/31/91	1.3150	0.9824
240057	01/01/91	12/31/91	1.7321	0.9983
240058	10/01/90	09/30/91	0.9987	0.9196
240059	10/01/90	09/30/91	1.1115	0.9747
240061	01/01/91	12/31/91	1.4353	0.9945
240063	09/01/90	08/31/91	1.4998	0.9888
240064	01/01/91	12/31/91	1.2106	0.9746
240065	01/01/90	09/30/91	1.0076	0.9619
240066	10/01/90	09/30/91	1.3516	0.9744
240069	01/01/91	12/31/91	1.1981	0.9719
240071	01/01/91	12/31/91	1.1188	0.9696
240072	01/01/91	12/31/91	0.9585	0.9362
240073	01/01/91	12/31/91	1.0173	0.9442
240076	01/01/91	12/31/91	1.1096	0.9678
240078	01/01/91	12/31/91	1.3928	0.9971
240079	10/01/90	09/30/91	1.0762	0.9690
240080	01/01/91	12/31/91	1.3699	0.9974
240082	01/01/91	12/31/91	1.1684	0.9856
240083	01/01/91	12/31/91	1.2498	0.9438
240084	01/01/91	12/31/91	1.2999	0.9674
240085	01/01/91	12/31/91	0.8611	0.9679
240086	10/01/90	09/30/91	1.0704	0.9846
240087	01/01/91	12/31/91	1.0593	0.9760
240088	01/01/91	12/31/91	1.4549	0.9729
240090	05/01/90	09/30/91	1.0207	0.9747
240091	01/01/91	12/31/91	0.9866	0.9792
240093	10/01/90	09/30/91	1.2947	0.9770
240094	10/01/90	09/30/91	1.0016	0.9046
240096	01/01/91	12/31/91	1.0241	0.9647
240097	01/01/91	12/31/91	1.1094	0.9322
240098	10/01/90	09/30/91	0.9247	0.9523
240100	12/01/90	11/30/91	1.3039	0.9824
240102	01/01/91	12/31/91	1.0884	0.9730
240103	10/01/90	09/30/91	1.1640	0.9721
240105	10/01/90	09/30/91	0.8942	0.9730
240106	01/01/91	12/31/91	1.3227	0.9916
240107	01/01/91	12/31/91	0.9526	0.9685
240108	10/01/90	09/30/91	0.9344	0.9673
240109	01/01/91	12/31/91	0.9792	0.9885
240111	01/01/91	12/31/91	0.9856	0.9450
240112	01/01/91	12/31/91	0.9702	0.9777
240114	01/01/91	12/31/91	1.0439	0.8536
240115	01/01/91	12/31/91	1.5609	0.9950
240116	10/01/90	09/30/91	0.9139	0.9547
240117	11/01/90	10/31/91	1.1304	0.8592
240119	01/01/91	12/31/91	0.9073	0.9444
240121	10/01/90	09/30/91	0.9304	0.9339
240122	10/01/90	09/30/91	1.0907	0.9756
240123	01/01/91	12/31/91	1.1197	0.9250
240124	01/01/91	12/31/91	1.0316	0.9671
240127	01/01/91	12/31/91	0.9813	0.9697
240128	01/01/91	12/31/91	1.1150	0.9765
240130	01/01/91	12/31/91	0.9835	0.9529
240132	01/01/91	12/31/91	1.2614	0.9847
240133	01/01/91	12/31/91	1.1554	0.9509
240135	10/01/90	09/30/91	0.8410	0.9697
240136	01/01/91	12/31/91	0.8833	0.9400
240138	10/01/90	09/30/91	0.8740	0.9631
240139	10/01/90	09/30/91	0.9807	0.9638

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
240140	01/01/91	12/31/91	0.7912	0.9409
240141	01/01/91	12/31/91	1.0218	0.9494
240142	01/01/91	12/31/91	1.0787	0.9875
240143	10/01/90	09/30/91	0.9575	0.9297
240144	01/01/91	12/31/91	0.9736	0.9386
240146	10/01/90	09/30/91	0.9870	0.9487
240148	01/01/91	12/31/91	0.9621	0.9524
240150	10/01/90	09/30/91	0.9483	0.9596
240152	01/01/91	12/31/91	0.9829	0.9522
240153	10/01/90	09/30/91	0.9831	0.9669
240154	01/01/91	12/31/91	0.9714	0.9641
240155	10/01/90	09/30/91	0.9229	0.8731
240157	09/01/90	08/31/91	1.0535	0.9566
240158	05/01/90	07/31/91	0.9470	0.9354
240161	10/01/90	09/30/91	0.9873	0.9617
240162	01/01/91	12/31/91	1.0559	0.9588
240163	01/01/91	12/31/91	0.9190	0.9400
240166	10/01/90	09/30/91	1.1563	0.9623
240169	01/01/91	12/31/91	0.9770	0.9579
240170	01/01/91	12/31/91	1.0848	0.9589
240172	01/01/91	12/31/91	1.1216	0.9530
240173	01/01/91	12/31/91	0.9711	0.9473
240176	10/01/90	09/30/91	0.8986	1.0000
240179	01/01/91	12/31/91	0.9851	0.9640
240180	01/01/91	12/31/91	0.9581	0.9602
240183	01/01/90	11/30/91	1.1558	0.9705
240184	10/01/90	09/30/91	1.0729	0.9631
240187	01/01/91	12/31/91	1.2212	0.9627
240192	01/01/91	12/31/91	0.9275	0.9593
240193	10/01/90	09/30/91	1.0762	0.9748
240196	01/01/91	12/31/91	1.2889	0.9965
240200	01/01/91	12/31/91	0.8728	0.8800
240201	01/01/90	08/14/91	1.0074	0.9734
240207	01/01/91	12/31/91	1.1590	0.9699
240210	09/01/90	08/31/91	1.2412	0.9828
240211	10/01/90	09/30/91	1.3121	1.0000
250002	10/01/90	09/30/91	0.8050	0.9495
250003	10/01/90	09/30/91	0.9659	0.9531
250004	10/01/90	09/30/91	1.4418	0.9980
250005	10/01/90	09/30/91	0.9575	0.9532
250007	10/01/90	09/30/91	1.1603	0.9924
250008	10/01/90	09/30/91	0.8875	0.9388
250009	10/01/90	09/30/91	1.0943	0.9637
250010	10/01/90	09/30/91	1.0839	0.9523
250012	01/01/91	12/31/91	0.9437	0.9543
250015	10/01/90	09/30/91	0.9458	0.9553
250016	05/01/90	12/31/91	0.8609	0.9958
250018	10/01/90	09/30/91	1.0173	0.9475
250019	10/01/90	09/30/91	1.2662	0.9974
250020	10/01/90	09/30/91	1.0173	0.9481
250021	10/01/90	09/30/91	0.8911	0.9606
250023	10/01/90	09/30/91	0.8304	0.9587
250024	10/01/90	09/30/91	0.9341	0.9660
250025	10/01/90	09/30/91	1.0210	0.9675
250027	10/01/90	09/30/91	0.9803	0.9632
250029	01/01/91	12/31/91	0.9321	0.9507
250030	01/01/91	12/31/91	0.9347	0.9669
250035	10/01/90	09/30/91	0.8378	0.9752
250036	10/01/90	09/30/91	0.9633	0.9609
250037	10/01/90	09/30/91	0.8884	0.9344
250038	10/01/90	09/30/91	0.8919	0.9677
250039	10/01/90	09/30/91	1.0096	0.9576
250040	10/01/90	09/30/91	1.2067	0.9923
250042	10/01/90	09/30/91	1.1284	0.9873
250043	10/01/90	09/30/91	0.8837	0.9441
250045	10/01/90	09/30/91	1.1650	0.9640
250047	10/01/90	09/30/91	0.9318	0.9740
250048	01/01/91	12/31/91	1.3615	0.9971
250049	10/01/90	09/30/91	0.9237	0.9751
250050	10/01/90	09/30/91	1.1686	0.9838
250051	10/01/90	09/30/91	0.8801	0.9581
250057	10/01/90	09/30/91	1.0856	0.9829
250058	10/01/90	09/30/91	1.1685	0.9877
250059	10/01/90	09/30/91	1.0076	0.9474
250060	10/01/90	09/30/91	0.7967	0.9510
250061	10/01/90	09/30/91	0.9080	0.9754
250062	01/01/91	12/31/91	0.9781	0.9618

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
250063	10/01/90	09/30/91	0.8544	0.9714
250065	10/01/90	09/30/91	0.9447	0.9680
250066	10/01/90	09/30/91	0.9373	0.9761
250067	10/01/90	09/30/91	1.0111	0.9850
250068	10/01/90	09/30/91	0.8492	0.9446
250069	01/01/91	12/31/91	1.2494	0.9942
250071	10/01/90	09/30/91	1.0477	0.9587
250073	01/01/91	12/31/91	0.9885	0.9520
250076	10/01/90	09/30/91	0.9145	0.9406
250077	10/01/90	09/30/91	0.9283	0.9710
250078	10/01/90	09/30/91	1.3873	0.9978
250079	10/01/90	09/30/91	0.8617	0.9617
250081	10/01/90	09/30/91	1.2182	0.9929
250082	10/01/90	09/30/91	1.2492	0.9907
250083	01/01/91	12/31/91	0.9028	0.9719
250084	10/01/90	09/30/91	1.1969	0.9947
250085	10/01/90	09/30/91	1.0031	0.9714
250086	10/01/90	09/30/91	0.9208	0.9686
250088	10/01/90	09/30/91	1.0110	0.9630
250089	01/01/91	12/31/91	0.9931	0.9799
250091	10/01/90	09/30/91	1.0214	0.9743
250093	10/01/90	09/30/91	1.1520	0.9887
250095	10/01/90	09/30/91	1.0467	0.9701
250096	10/01/90	09/30/91	1.1961	0.9897
250097	10/01/90	09/30/91	1.1841	0.9744
250098	10/01/90	09/30/91	0.8416	0.9454
250099	10/01/90	09/30/91	1.2073	0.9846
250100	10/01/90	09/30/91	1.1521	0.9633
250101	10/01/90	09/30/91	0.8836	0.9784
250104	10/01/90	09/30/91	1.3148	0.9981
250105	10/01/90	09/30/91	0.9041	0.9587
250107	10/01/90	09/30/91	0.9158	0.9696
250109	10/01/90	09/30/91	0.9824	0.9523
250112	10/01/90	09/30/91	0.9499	0.9660
250117	01/01/91	12/31/91	1.1020	0.9834
250119	10/01/90	09/30/91	0.9624	0.9716
250120	10/01/90	09/30/91	1.0683	0.9922
250122	09/01/90	08/31/91	1.2603	0.9946
250124	01/01/91	12/31/91	0.8784	0.9662
250125	01/01/91	12/31/91	1.2835	0.9889
250129	09/01/90	12/31/91	1.1708	0.9882
250136	01/01/91	12/31/91	0.7666	1.0000
250139	10/01/90	09/30/91	0.9012	0.9588
250140	10/01/90	09/30/91	0.8143	0.9870
260003	09/01/90	08/31/91	0.9668	0.9558
260004	01/01/91	12/31/91	1.0707	0.9824
260005	01/01/91	12/31/91	1.3836	0.9949
260011	01/01/91	12/31/91	1.5313	0.9945
260012	10/01/90	09/30/91	1.0062	0.9673
260014	01/01/91	12/31/91	1.6131	0.9989
260015	01/01/91	12/31/91	1.2203	0.9493
260017	01/01/91	12/31/91	1.2136	0.9785
260018	10/01/90	09/30/91	0.9483	0.9429
260019	01/01/91	12/31/91	1.0231	0.9666
260021	10/01/90	09/30/91	1.2800	0.9924
260023	10/01/90	09/30/91	1.2745	0.9934
260024	12/01/90	11/30/91	1.0524	0.9867
260025	10/01/90	09/30/91	1.3079	0.9813
260027	01/01/91	12/31/91	1.5166	0.9984
260029	10/01/90	09/30/91	1.1625	0.9783
260030	10/01/90	09/30/91	1.1174	0.9796
260032	01/01/91	12/31/91	1.6358	0.9981
260034	01/01/91	12/31/91	1.0373	0.9816
260035	12/01/90	11/30/91	1.0507	0.9777
260036	01/01/91	12/31/91	1.0389	0.9531
260039	09/01/90	08/31/91	1.3077	0.9722
260040	10/01/90	09/30/91	1.4982	0.9989
260044	01/01/91	12/31/91	1.0679	0.9801
260050	01/01/91	12/31/91	1.0874	0.9675
260053	10/01/90	09/30/91	1.0735	0.9840
260054	01/01/91	12/31/91	1.3418	0.9941
260057	10/01/90	09/30/91	1.1603	0.9797
260062	10/01/90	09/30/91	1.1677	0.9853
260063	01/01/91	12/31/91	1.1645	0.9647
260064	01/01/91	12/31/91	1.3670	0.9869
260068	01/01/91	12/31/91	1.7744	0.9994
260070	01/01/91	12/31/91	1.1166	0.9389

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
260073	01/01/91	12/31/91	1.0164	0.9714
260074	01/01/91	12/31/91	1.1967	0.9679
260078	01/01/91	12/31/91	1.1004	0.9761
260080	09/01/90	08/31/91	1.1325	0.9173
260091	01/01/91	12/31/91	1.5519	0.9970
260092	01/01/91	12/31/91	1.0959	0.9632
260097	10/01/90	09/30/91	1.1887	0.9691
260100	10/01/90	09/30/91	1.1553	0.9746
260102	01/01/91	12/31/91	0.9515	0.9748
260103	01/01/91	12/31/91	1.3060	0.9918
260107	10/01/90	09/30/91	1.3056	0.9994
260110	01/01/91	12/31/91	1.6245	0.9980
260111	01/01/91	12/31/91	0.9776	0.9668
260113	10/01/90	09/30/91	1.1684	0.9859
260116	01/01/91	12/31/91	1.2021	0.9887
260119	01/01/91	12/31/91	1.1421	0.9700
260120	12/01/90	11/30/91	1.1855	0.9719
260122	11/01/90	10/31/91	1.2564	0.9749
260123	01/01/91	12/31/91	0.9326	0.9846
260134	01/01/91	12/31/91	1.2845	0.9848
260138	01/01/91	12/31/91	1.8406	0.9990
260158	01/01/91	12/31/91	1.0872	0.9730
260159	01/01/91	12/31/91	1.1101	0.9713
260160	01/01/91	12/31/91	1.1429	0.9707
260162	01/01/91	12/31/91	1.0360	0.9749
260165	01/01/91	12/31/91	0.9467	0.9723
260166	01/01/91	12/31/91	1.2226	0.9886
260178	01/01/91	12/31/91	1.4275	0.9959
260179	01/01/91	12/31/91	1.5147	0.9993
260180	01/01/91	12/31/91	1.5581	0.9964
260182	07/01/90	09/30/91	1.0276	0.9673
260188	01/01/91	12/31/91	1.1871	0.9805
260190	01/01/91	12/31/91	1.1618	0.9923
260191	01/01/91	12/31/91	1.2471	0.9840
260193	01/01/91	12/31/91	1.2247	0.9822
260195	09/28/90	09/26/91	1.1173	0.9634
260198	07/01/90	10/31/91	1.2658	0.9809
260200	01/01/91	12/31/91	1.1923	0.9687
260202	10/01/90	09/30/91	1.3740	0.9754
270002	10/01/90	09/30/91	1.2246	0.9838
270006	10/01/90	09/30/91	0.8607	1.0000
270007	10/01/90	09/30/91	0.9594	0.9566
270013	01/01/91	12/31/91	1.3018	0.9888
270014	01/01/91	12/31/91	1.6441	0.9968
270019	01/01/91	12/31/91	0.9794	0.9594
270021	10/01/90	09/30/91	1.0866	0.9896
270030	01/01/91	12/31/91	0.9277	0.9168
270033	01/01/91	12/31/91	0.8019	0.9586
270035	10/01/90	09/30/91	1.0434	0.9849
270039	01/01/91	12/31/91	0.9036	0.9673
270048	11/01/90	10/31/91	1.0827	0.9698
270057	01/01/91	12/31/91	1.1048	0.9834
270059	11/01/90	10/31/91	0.8522	0.9605
270063	10/01/90	09/30/91	0.8775	0.9807
270083	01/01/91	12/31/91	1.0149	0.9535
280001	10/01/90	09/30/91	1.1286	0.9485
280005	09/01/90	08/31/91	1.4427	0.9914
280012	01/01/91	12/31/91	1.1809	0.9853
280015	10/01/90	09/30/91	1.0098	0.9808
280017	08/01/90	07/31/91	1.1658	0.9673
280025	09/01/90	08/31/91	0.9861	0.9612
280030	09/01/90	08/31/91	1.7555	0.9983
280031	10/01/90	09/30/91	1.1035	0.9736
280032	01/01/91	12/31/91	1.2118	0.9915
280034	09/01/90	08/31/91	1.2686	0.9887
280038	10/01/90	09/30/91	1.0332	0.9771
280039	10/01/90	09/30/91	1.0738	0.9458
280040	01/01/91	12/31/91	1.5883	0.9944
280041	01/01/91	12/31/91	0.9268	0.9894
280046	01/01/91	12/31/91	1.0125	0.9727
280047	01/01/91	12/31/91	1.1805	0.9672
280048	10/01/90	09/30/91	1.0651	0.9972
280054	10/01/90	09/30/91	1.1591	0.9721
280057	10/01/90	09/30/91	1.0140	0.9793
280058	10/01/90	09/30/91	1.2385	0.9643
280061	01/01/91	12/31/91	1.3005	0.9937
280065	01/01/91	12/31/91	1.1577	0.9860

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
280074	10/01/90	09/30/91	1.1618	0.9805
280076	08/01/90	07/31/91	0.9625	0.9490
280078	05/01/90	10/18/91	0.9264	0.9093
280079	08/01/90	07/31/91	0.9452	0.9814
280081	10/01/90	09/30/91	1.4439	0.9969
280083	11/01/90	10/31/91	0.9812	0.9637
280085	01/01/91	12/31/91	0.9515	1.0000
280088	09/24/90	09/22/91	1.6348	0.9984
280089	10/01/90	09/30/91	1.0325	0.9939
280101	10/01/90	09/30/91	1.1227	0.9959
280102	01/01/91	12/31/91	0.8383	0.9334
280106	08/01/90	07/31/91	1.0201	0.9756
280107	11/01/90	10/31/91	1.0708	0.9474
280108	01/01/91	12/31/91	1.0423	0.9874
280109	08/01/90	07/31/91	0.9163	0.9805
280114	08/01/90	07/31/91	0.9298	0.9880
280115	01/01/91	12/31/91	0.9729	0.9705
290003	09/01/90	08/31/91	1.6223	0.9983
290005	09/01/90	08/31/91	1.1910	0.9932
290006	01/01/91	12/31/91	1.0680	0.9722
290009	01/01/91	12/31/91	1.5643	0.9964
290010	01/01/91	12/31/91	1.0543	0.9828
290018	10/01/90	09/30/91	0.9938	0.9543
290021	01/01/91	12/31/91	1.5631	0.9982
290022	10/01/90	09/30/91	1.6766	0.9987
290032	01/01/91	12/31/91	1.3852	0.9780
300001	10/01/90	09/30/91	1.2908	0.9955
300005	10/01/90	09/30/91	1.3439	0.9930
300006	10/01/90	09/30/91	1.1131	0.9585
300007	10/01/90	09/30/91	1.1022	0.9757
300008	10/01/90	09/30/91	1.2357	0.9915
300009	10/01/90	09/30/91	1.2334	0.9555
300011	01/01/91	12/31/91	1.2347	0.9936
300012	10/01/90	09/30/91	1.2615	0.9809
300013	10/01/90	09/30/91	1.1566	0.9612
300014	10/01/90	09/30/91	1.3455	0.9915
300016	10/01/90	09/30/91	1.2373	0.9888
300017	08/01/90	07/31/91	1.1791	0.9793
300018	01/01/91	12/31/91	1.1924	0.9926
300020	10/01/90	09/30/91	1.1541	0.9928
300021	10/01/90	09/30/91	1.1561	0.9849
300022	01/01/91	12/31/91	1.1134	0.9653
300023	10/01/90	09/30/91	1.2241	0.9822
300024	10/01/90	09/30/91	1.2564	0.9767
300028	10/01/90	09/30/91	1.1812	0.9707
300033	10/01/90	09/30/91	1.0753	0.9748
310001	01/01/91	12/31/91	1.6577	0.9995
310002	01/01/91	12/31/91	1.8318	0.9986
310003	01/01/91	12/31/91	1.2299	0.9940
310005	01/01/91	12/31/91	1.2373	0.9909
310006	01/01/91	12/31/91	1.1527	0.9942
310008	01/01/91	12/31/91	1.3263	0.9948
310009	01/01/91	12/31/91	1.1823	0.9963
310010	01/01/91	12/31/91	1.2262	0.9938
310011	01/01/91	12/31/91	1.2183	0.9833
310012	01/01/91	12/31/91	1.5608	0.9988
310013	01/01/91	12/31/91	1.2893	0.9969
310014	01/01/91	12/31/91	1.6075	0.9973
310015	01/01/91	12/31/91	1.6005	0.9989
310016	01/01/91	12/31/91	1.2585	0.9984
310017	01/01/91	12/31/91	1.3329	0.9902
310018	01/01/91	12/31/91	1.2422	0.9941
310019	01/01/91	12/31/91	1.6587	0.9982
310020	01/01/91	12/31/91	1.2177	0.9952
310021	01/01/91	12/31/91	1.2315	0.9940
310022	01/01/91	12/31/91	1.2058	0.9936
310024	01/01/91	12/31/91	1.2351	0.9907
310025	01/01/91	12/31/91	1.1611	0.9896
310026	01/01/91	12/31/91	1.2179	0.9952
310027	01/01/91	12/31/91	1.2667	0.9949
310028	01/01/91	12/31/91	1.1674	0.9790
310029	01/01/91	12/31/91	1.8063	0.9956
310031	01/01/91	12/31/91	2.7639	0.9966
310032	01/01/91	12/31/91	1.2887	0.9876
310034	01/01/91	12/31/91	1.1591	0.9933
310036	01/01/91	12/31/91	1.2208	0.9913
310037	01/01/91	12/31/91	1.2156	0.9924

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
310038	01/01/91	12/31/91	1.7265	0.9977
310039	01/01/91	12/31/91	1.2903	0.9970
310040	01/01/91	12/31/91	1.2030	0.9987
310041	01/01/91	12/31/91	1.2659	0.9951
310042	01/01/91	12/31/91	1.1365	0.9967
310043	01/01/91	12/31/91	1.1940	0.9944
310044	01/01/91	12/31/91	1.2474	0.9923
310045	01/01/91	12/31/91	1.2620	0.9968
310047	01/01/91	12/31/91	1.2770	0.9883
310048	01/01/91	12/31/91	1.2203	0.9942
310049	01/01/91	12/31/91	1.2695	0.9971
310050	10/01/90	09/30/91	1.1906	0.9933
310051	01/01/91	12/31/91	1.2875	0.9943
310052	01/01/91	12/31/91	1.1881	0.9936
310054	01/01/91	12/31/91	1.2728	0.9950
310056	01/01/91	12/31/91	1.1524	0.9850
310057	01/01/91	12/31/91	1.2381	0.9921
310058	01/01/91	12/31/91	1.1516	0.9962
310060	01/01/91	12/31/91	1.1951	0.9931
310061	01/01/91	12/31/91	1.1779	0.9874
310062	01/01/91	12/31/91	1.1892	0.9972
310063	01/01/91	12/31/91	1.3007	0.9949
310064	01/01/91	12/31/91	1.2243	0.9919
310067	01/01/91	12/31/91	1.2155	0.9927
310069	01/01/91	12/31/91	1.1418	0.9782
310070	01/01/91	12/31/91	1.2847	0.9963
310071	01/01/91	12/31/91	0.6936	1.0000
310072	01/01/91	12/31/91	1.2939	0.9886
310073	01/01/91	12/31/91	1.3973	0.9981
310074	01/01/91	12/31/91	1.2923	0.9938
310075	01/01/91	12/31/91	1.2579	0.9944
310076	01/01/91	12/31/91	1.3520	0.9964
310077	01/01/91	12/31/91	1.5813	0.9981
310078	01/01/91	12/31/91	1.3174	0.9988
310081	01/01/91	12/31/91	1.2105	0.9903
310083	01/01/91	12/31/91	1.2825	0.9971
310084	01/01/91	12/31/91	1.2199	0.9941
310085	01/01/91	12/31/91	1.2154	0.9963
310086	01/01/91	12/31/91	1.1849	0.9916
310087	01/01/91	12/31/91	1.1833	0.9822
310088	01/01/91	12/31/91	1.2435	0.9881
310090	01/01/91	12/31/91	1.2598	0.9905
310091	01/01/91	12/31/91	1.2488	0.9865
310092	01/01/91	12/31/91	1.3295	0.9951
310093	01/01/91	12/31/91	1.1019	0.9937
310096	01/01/91	12/31/91	1.7318	0.9980
310105	01/01/91	12/31/91	1.1204	0.9906
310108	01/01/91	12/31/91	1.3575	0.9955
310110	01/01/91	12/31/91	1.2319	0.9947
310111	01/01/91	12/31/91	1.2379	0.9924
310112	01/01/91	12/31/91	1.2275	0.9966
310113	01/01/91	12/31/91	1.2209	0.9844
310115	01/01/91	12/31/91	1.1913	0.9933
310116	01/01/91	12/31/91	1.2660	0.9939
310118	10/01/90	09/30/91	1.2049	0.9943
310120	01/01/91	12/31/91	1.0594	0.9923
310121	01/01/91	12/31/91	1.0688	0.9034
320019	09/01/90	08/31/91	1.3408	0.9977
320035	01/01/91	12/31/91	1.0556	0.9691
320038	09/01/90	08/31/91	1.2492	0.9602
320048	07/01/90	12/31/91	1.2824	0.9958
320063	09/01/90	08/31/91	1.2816	0.9786
320067	01/01/91	12/31/91	0.8769	0.9847
330001	01/01/91	12/31/91	1.1577	0.9891
330002	01/01/91	12/31/91	1.4261	0.9966
330003	01/01/91	12/31/91	1.3330	0.9963
330004	01/01/91	12/31/91	1.3560	0.9958
330005	01/01/91	12/31/91	1.6850	0.9995
330006	01/01/91	12/31/91	1.3704	0.9932
330007	01/01/91	12/31/91	1.3633	0.9945
330008	01/01/91	12/31/91	1.1902	0.9903
330009	01/01/91	12/31/91	1.3196	0.9975
330010	01/01/91	12/31/91	1.2416	0.9874
330011	01/01/91	12/31/91	1.1795	0.9954
330012	01/01/91	12/31/91	1.5904	0.9953
330013	01/01/91	12/31/91	2.0580	0.9963
330014	01/01/91	12/31/91	1.4092	0.9928

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330015	01/01/91	12/31/91	0.8736	1.0000
330016	01/01/91	12/31/91	0.9805	0.9757
330019	01/01/91	12/31/91	1.3070	0.9951
330020	01/01/91	12/31/91	0.9994	0.9808
330022	01/01/91	12/31/91	0.9905	0.9736
330023	01/01/91	12/31/91	1.2098	0.9890
330024	01/01/91	12/31/91	1.7348	0.9996
330025	01/01/91	12/31/91	1.1008	0.9911
330027	01/01/91	12/31/91	1.4005	0.9826
330028	01/01/91	12/31/91	1.3003	0.9943
330029	01/01/91	12/31/91	1.1108	0.9936
330030	01/01/91	12/31/91	1.1574	0.9916
330033	01/01/91	12/31/91	1.1226	0.9820
330034	01/01/91	12/31/91	1.0669	0.9949
330036	01/01/91	12/31/91	1.1939	0.9928
330037	01/01/91	12/31/91	1.0528	0.9882
330038	01/01/91	12/31/91	1.1852	0.9874
330039	01/01/91	12/31/91	0.8981	0.9704
330041	01/01/91	12/31/91	1.3626	0.9975
330043	01/01/91	12/31/91	1.2430	0.9917
330044	01/01/91	12/31/91	1.1996	0.9938
330045	01/01/91	12/31/91	1.3076	0.9949
330046	01/01/91	12/31/91	1.5956	0.9973
330047	01/01/91	12/31/91	1.2635	0.9947
330048	01/01/91	12/31/91	1.2585	0.9915
330049	01/01/91	12/31/91	1.3039	0.9893
330053	01/01/91	12/31/91	1.0465	0.9921
330055	01/01/91	12/31/91	1.3877	0.9955
330056	01/01/91	12/31/91	1.4353	0.9980
330057	01/01/91	12/31/91	1.5729	0.9981
330058	01/01/91	12/31/91	1.3215	0.9904
330059	01/01/91	12/31/91	1.4891	0.9993
330061	01/01/91	12/31/91	1.3168	0.9957
330062	01/01/91	12/31/91	1.0897	0.9747
330064	01/01/91	12/31/91	1.3062	0.9964
330065	01/01/91	12/31/91	1.1855	0.9948
330066	01/01/91	12/31/91	1.2114	0.9961
330067	01/01/91	12/31/91	1.3305	0.9893
330072	01/01/91	12/31/91	1.3365	0.9963
330073	01/01/91	12/31/91	1.1686	0.9859
330074	01/01/91	12/31/91	1.2262	0.9920
330075	01/01/91	12/31/91	1.0491	0.9885
330078	01/01/91	12/31/91	1.3601	0.9965
330079	01/01/91	12/31/91	1.1036	0.9868
330082	01/01/91	12/31/91	1.2040	0.9919
330084	01/01/91	12/31/91	0.9497	0.9793
330085	01/01/91	12/31/91	1.3489	0.9925
330086	01/01/91	12/31/91	1.2678	0.9952
330088	01/01/91	12/31/91	1.0996	0.9793
330090	01/01/91	12/31/91	1.7093	0.9968
330091	01/01/91	12/31/91	1.3826	0.9953
330092	01/01/91	12/31/91	0.9649	0.9776
330094	01/01/91	12/31/91	1.2793	0.9899
330095	01/01/91	12/31/91	1.2530	0.9972
330097	01/01/91	12/31/91	1.1576	0.9919
330100	01/01/91	12/31/91	0.6753	0.9978
330101	01/01/91	12/31/91	1.6301	0.9980
330102	01/01/91	12/31/91	1.2835	0.9979
330103	01/01/91	12/31/91	1.1719	0.9840
330104	01/01/91	12/31/91	1.3352	0.9935
330106	01/01/91	12/31/91	1.5305	0.9993
330107	01/01/91	12/31/91	1.2543	0.9808
330108	01/01/91	12/31/91	1.2213	0.9929
330110	01/01/91	12/31/91	1.0812	0.9801
330111	01/01/91	12/31/91	1.1379	0.9715
330114	01/01/91	12/31/91	0.9716	0.9647
330115	01/01/91	12/31/91	1.2007	0.9777
330116	01/01/91	12/31/91	0.9737	0.9632
330118	01/01/91	12/31/91	1.5710	0.9979
330119	01/01/91	12/31/91	1.6069	0.9992
330121	01/01/91	12/31/91	0.9922	0.9870
330122	01/01/91	12/31/91	1.3014	0.9934
330125	01/01/91	12/31/91	1.7736	0.9982
330126	01/01/91	12/31/91	1.2054	0.9868
330132	01/01/91	12/31/91	1.1018	0.9816
330133	01/01/91	12/31/91	1.2999	0.9964
330135	01/01/91	12/31/91	1.2178	0.9804

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330136	01/01/91	12/31/91	1.2479	0.9881
330140	01/01/91	12/31/91	1.6427	0.9981
330141	01/01/91	12/31/91	1.2623	0.9958
330144	01/01/91	12/31/91	1.0315	0.9764
330148	01/01/91	12/31/91	1.0184	0.9789
330151	01/01/91	12/31/91	1.1353	0.9826
330152	01/01/91	12/31/91	1.3951	0.9949
330153	01/01/91	12/31/91	1.3152	0.9944
330154	01/01/91	12/31/91	1.4343	0.9995
330155	01/01/91	12/31/91	1.1867	0.9777
330157	01/01/91	12/31/91	1.3015	0.9916
330158	01/01/91	12/31/91	1.2923	0.9946
330159	01/04/91	12/31/91	1.3053	0.9925
330160	01/01/91	12/31/91	1.4509	0.9968
330161	01/01/91	12/31/91	1.0523	0.9929
330162	01/01/91	12/31/91	1.2550	0.9947
330163	01/01/91	12/31/91	1.1614	0.9951
330164	01/01/91	12/31/91	1.3725	0.9963
330166	01/01/91	12/31/91	0.9165	0.9666
330167	01/01/91	12/31/91	1.5388	0.9978
330169	01/01/91	12/31/91	1.3878	0.9965
330171	01/01/91	12/31/91	1.2918	0.9960
330174	01/01/91	12/31/91	0.6686	0.8339
330175	01/01/91	12/31/91	1.0456	0.9932
330179	01/01/91	12/31/91	0.9425	0.9864
330180	01/01/91	12/31/91	1.2191	0.9948
330181	01/01/91	12/31/91	1.2596	0.9972
330182	01/01/91	12/31/91	2.2788	0.9988
330183	01/01/91	12/31/91	1.4314	0.9944
330184	01/01/91	12/31/91	1.2307	0.9917
330185	01/01/91	12/31/91	1.1676	0.9931
330186	01/01/91	12/31/91	0.9769	0.9685
330188	01/01/91	12/31/91	1.2120	0.9956
330189	01/01/91	12/31/91	0.8722	1.0000
330191	01/01/91	12/31/91	1.2472	0.9965
330193	01/01/91	12/31/91	1.3380	0.9962
330194	01/01/91	12/31/91	1.7382	0.9990
330195	01/01/91	12/31/91	1.6286	0.9973
330197	01/01/91	12/31/91	1.0129	0.9826
330198	01/01/91	12/31/91	1.3286	0.9941
330201	01/01/91	12/31/91	1.5001	0.9935
330203	01/01/91	12/31/91	1.3978	0.9974
330205	01/01/91	12/31/91	1.0892	0.9820
330208	01/01/91	12/31/91	1.1677	0.9955
330209	01/01/91	12/31/91	1.2120	0.9854
330211	01/01/91	12/31/91	1.2443	0.9868
330212	01/01/91	12/31/91	1.2332	0.9959
330213	01/01/91	12/31/91	1.1090	0.9704
330214	01/01/91	12/31/91	1.7320	0.9992
330215	01/01/91	12/31/91	1.2038	0.9923
330218	01/01/91	12/31/91	1.2668	0.9906
330219	01/01/91	12/31/91	1.5482	0.9984
330221	01/01/91	12/31/91	1.2762	0.9962
330222	01/01/91	12/31/91	1.2217	0.9886
330223	01/01/91	12/31/91	1.0822	0.9742
330224	01/01/91	12/31/91	1.2347	0.9946
330225	01/01/91	12/31/91	1.1868	0.9958
330226	01/01/91	12/31/91	1.2793	0.9916
330229	01/01/91	12/31/91	1.2083	0.9824
330230	01/01/91	12/31/91	1.4617	0.9948
330232	01/01/91	12/31/91	1.2602	0.9973
330233	01/01/91	12/31/91	1.5136	0.9971
330235	01/01/91	12/31/91	1.2051	0.9855
330236	01/01/91	12/31/91	1.3353	0.9951
330238	01/01/91	12/31/91	1.0762	0.9875
330239	01/01/91	12/31/91	1.1767	0.9945
330241	01/01/91	12/31/91	1.7846	0.9952
330242	01/01/91	12/31/91	1.2800	0.9967
330244	01/01/91	12/31/91	1.0915	0.9987
330245	01/01/91	12/31/91	1.3205	0.9877
330246	01/01/91	12/31/91	1.2066	0.9948
330247	01/01/91	12/31/91	0.6192	1.0000
330249	01/01/91	12/31/91	1.2142	0.9823
330250	01/01/91	12/31/91	1.2671	0.9949
330252	01/01/91	12/31/91	0.9231	0.9485
330254	01/01/91	12/31/91	1.0081	0.9888
330258	01/01/91	12/31/91	1.3424	0.9911

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330259	01/01/91	12/31/91	1.3447	0.9959
330261	01/01/91	12/31/91	1.2431	0.9940
330263	01/01/91	12/31/91	1.0611	0.9799
330264	01/01/91	12/31/91	1.1762	0.9920
330265	01/01/91	12/31/91	1.2462	0.9943
330267	01/01/91	12/31/91	1.2433	0.9934
330268	01/01/91	12/31/91	1.1202	0.9727
330270	01/01/91	12/31/91	1.8605	0.9971
330273	01/01/91	12/31/91	1.2056	0.9893
330275	01/01/91	12/31/91	1.2347	0.9981
330276	01/01/91	12/31/91	1.2125	0.9847
330277	01/01/91	12/31/91	1.1833	0.9831
330279	01/01/91	12/31/91	1.2308	0.9953
330281	01/01/91	12/31/91	0.5490	1.0000
330285	01/01/91	12/31/91	1.6676	0.9977
330286	01/01/91	12/31/91	1.3184	0.9919
330288	01/01/91	12/31/91	1.0362	0.9839
330290	01/01/91	12/31/91	1.6676	0.9981
330293	01/01/91	12/31/91	1.1914	0.9938
330304	01/01/91	12/31/91	1.1936	0.9915
330306	01/01/91	12/31/91	1.3668	0.9961
330307	01/01/91	12/31/91	1.1312	0.9812
330308	01/01/91	12/31/91	1.2220	0.9968
330309	01/01/91	12/31/91	1.2797	0.9963
330314	01/01/91	12/31/91	1.3124	0.9937
330315	01/01/91	12/31/91	1.1847	0.9917
330316	01/01/91	12/31/91	1.2838	0.9926
330327	01/01/91	12/31/91	0.9646	0.9763
330331	01/01/91	12/31/91	1.1964	0.9942
330332	01/01/91	12/31/91	1.2709	0.9950
330333	01/01/91	12/31/91	1.3218	0.9976
330336	01/01/91	12/31/91	1.2602	0.9863
330338	01/01/91	12/31/91	1.1473	0.9937
330339	01/01/91	12/31/91	0.8252	1.0000
330340	01/01/91	12/31/91	1.1362	0.9791
330350	01/01/91	12/31/91	1.8601	0.9970
330353	01/01/91	12/31/91	1.2202	0.9916
330357	01/01/91	12/31/91	1.3670	0.9875
330359	01/01/91	12/31/91	0.9375	0.9742
330372	01/01/91	12/31/91	1.2491	0.9920
330381	01/01/91	12/31/91	1.2263	0.9986
330386	01/01/91	12/31/91	1.1966	0.9701
330387	01/01/91	12/31/91	0.8518	0.9429
330389	01/01/91	12/31/91	1.8306	0.9943
330390	01/01/91	12/31/91	1.1703	1.0000
330393	01/01/91	12/31/91	1.6281	0.9975
330394	01/01/91	12/31/91	1.3967	0.9985
330395	01/01/91	12/31/91	1.3223	0.9926
330397	01/01/91	12/31/91	1.4223	0.9962
330398	01/01/91	12/31/91	1.2796	0.9909
330399	01/01/91	12/31/91	1.3598	0.9982
340001	10/01/90	09/30/91	1.2428	0.9817
340002	10/01/90	09/30/91	1.7824	0.9964
340003	10/01/90	09/30/91	1.1463	0.9553
340004	10/01/90	09/30/91	1.3921	0.9937
340005	10/01/90	09/30/91	1.2275	0.9861
340006	10/01/90	09/30/91	1.1724	0.9682
340007	10/01/90	09/30/91	1.1175	0.9733
340008	10/01/90	09/30/91	1.2245	0.9822
340009	10/01/90	09/30/91	1.2459	0.9868
340010	09/24/90	09/28/91	1.3121	0.9770
340011	10/01/90	09/30/91	1.0776	0.9767
340012	10/01/90	09/30/91	1.0763	0.9854
340013	10/01/90	09/30/91	1.1930	0.9735
340015	10/01/90	09/30/91	1.2281	0.9777
340016	10/01/90	09/30/91	1.2019	0.9800
340017	10/01/90	09/30/91	1.2022	0.9854
340018	10/01/90	09/30/91	1.2033	0.9711
340021	10/01/90	09/30/91	1.2187	0.9865
340022	10/01/90	09/30/91	1.1383	0.9590
340023	01/01/91	12/31/91	1.3119	0.9881
340024	10/01/90	09/30/91	1.2321	0.9600
340025	10/01/90	09/30/91	1.0963	0.9850
340027	10/01/90	09/30/91	1.1213	0.9936
340028	10/01/90	09/30/91	1.3819	0.9923
340031	10/01/90	09/30/91	1.0763	0.9821
340034	10/01/90	09/30/91	1.2825	0.9615

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
340035	10/01/90	09/30/91	1.0860	0.9740
340036	10/01/90	09/30/91	1.0823	0.9596
340037	10/01/90	09/30/91	1.2533	0.8862
340038	10/01/90	09/30/91	1.2044	0.9839
340039	10/01/90	09/30/91	1.2308	0.9804
340040	10/01/90	09/30/91	1.7185	0.9991
340041	10/01/90	09/30/91	1.2352	0.9717
340042	10/01/90	09/30/91	1.1506	0.9799
340044	10/01/90	09/30/91	1.0088	0.9562
340045	10/01/90	09/30/91	0.9709	0.9405
340049	10/01/90	09/30/91	0.5900	1.0000
340050	10/01/90	09/30/91	1.2031	0.9736
340051	10/01/90	09/30/91	1.2320	0.9774
340052	10/01/90	09/30/91	0.9564	0.9778
340053	10/01/90	09/30/91	1.5728	0.9980
340054	10/01/90	09/30/91	0.9768	0.9722
340055	10/01/90	09/30/91	1.1573	0.9892
340060	10/01/90	09/30/91	1.1815	0.9659
340063	10/01/90	09/30/91	1.0201	0.9685
340064	10/01/90	09/30/91	1.0986	0.9630
340065	10/01/90	09/30/91	1.2349	0.9662
340067	10/01/90	09/30/91	1.1112	0.9704
340068	10/01/90	09/30/91	1.2557	0.9721
340069	10/01/90	09/30/91	1.7419	0.9962
340070	10/01/90	09/30/91	1.2917	0.9733
340071	10/01/90	09/30/91	1.0850	0.9583
340072	10/01/90	09/30/91	1.0490	0.9740
340075	10/01/90	09/30/91	1.1890	0.9832
340080	10/01/90	09/30/91	1.0912	0.9713
340084	10/01/90	09/30/91	1.0187	0.9836
340085	10/01/90	09/30/91	1.2491	0.9873
340087	10/01/90	09/30/91	1.0739	0.9804
340088	10/01/90	09/30/91	1.0851	0.9628
340089	10/01/90	09/30/91	1.0024	0.9645
340090	10/01/90	09/30/91	1.1459	0.9571
340091	10/01/90	09/30/91	1.6608	0.9989
340093	10/01/90	09/30/91	1.0467	0.9813
340094	10/01/90	09/30/91	1.3460	0.9861
340096	10/01/90	09/30/91	1.2126	0.9677
340097	10/01/90	09/30/91	1.0050	0.9631
340098	09/30/90	09/28/91	1.6140	0.9972
340099	10/01/90	09/30/91	1.1447	0.9681
340100	10/01/89	09/30/91	1.2013	0.9880
340101	01/01/91	12/31/91	1.0685	0.9624
340104	10/01/90	09/30/91	1.0045	0.9909
340105	10/01/90	09/30/91	1.3333	0.9963
340106	10/01/90	09/30/91	1.1011	0.9649
340107	01/01/91	12/31/91	1.3185	0.9798
340109	10/01/90	09/30/91	1.2925	0.9815
340111	10/01/90	09/30/91	1.1769	0.9594
340112	10/01/90	09/30/91	1.0080	0.9663
340113	10/01/90	09/30/91	1.9529	0.9990
340114	10/01/90	09/30/91	1.3834	0.9974
340115	10/01/90	09/30/91	1.4477	0.9955
340119	10/01/90	09/30/91	1.2129	0.9782
340120	10/01/90	09/30/91	1.0568	0.9497
340121	10/01/90	09/30/91	0.9505	0.9729
340122	10/01/90	09/30/91	1.0412	0.9621
340123	10/01/90	09/30/91	1.2013	0.9656
340124	10/01/90	09/30/91	1.0945	0.9515
340125	10/01/90	09/30/91	1.4419	0.9901
340126	10/01/90	09/30/91	1.2851	0.9815
340127	10/01/90	09/30/91	1.2221	0.9664
340129	10/01/90	09/30/91	1.1279	0.9783
340130	10/01/90	09/30/91	1.4048	0.9724
340131	10/01/90	09/30/91	1.3438	0.9910
340132	10/01/90	09/30/91	1.3693	0.9628
340133	10/01/90	09/30/91	1.2042	0.9541
340141	10/01/90	09/30/91	1.5276	0.9974
340142	10/01/90	09/30/91	1.1672	0.9757
340145	10/01/90	09/30/91	1.1948	0.9730
340146	10/01/90	09/30/91	1.0162	0.9637
340147	10/07/90	10/05/91	1.2836	0.9928
340151	10/01/90	09/30/91	1.1661	0.9810
340159	10/01/90	09/30/91	1.2011	0.9535
340162	01/01/91	12/31/91	1.2550	0.9868
340166	10/01/90	09/30/91	1.3215	0.9914

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
340168	10/01/90	09/30/91	0.5394	1.0000
350004	10/01/90	09/30/91	1.8750	0.9985
350007	10/01/90	09/30/91	1.0198	0.9563
350015	01/01/91	12/31/91	1.5242	0.9954
350016	01/01/91	12/31/91	0.9758	0.9885
350018	10/01/90	09/30/91	1.0307	0.9727
350019	01/01/91	12/31/91	1.5200	0.9965
350020	10/01/90	09/30/91	1.3390	0.9893
350023	01/01/91	12/31/91	0.9428	0.9948
350024	10/01/90	09/30/91	1.0004	0.9851
350027	10/01/90	09/30/91	0.9808	0.9883
350032	07/01/90	12/29/91	1.1451	1.0000
350033	01/01/91	12/31/91	0.9818	0.9844
350038	01/01/91	12/31/91	0.9640	0.9639
350041	01/01/91	12/31/91	0.9867	0.9742
350042	01/01/91	12/31/91	0.9259	0.9937
350051	01/01/91	12/31/91	0.9237	0.9761
350055	01/01/91	12/31/91	0.9464	0.9433
350066	10/01/90	09/30/91	0.9845	0.9509
360001	01/01/91	12/31/91	1.2267	0.9897
360002	01/01/91	12/31/91	1.1530	0.9758
360007	01/01/91	12/31/91	1.1598	0.9850
360009	01/01/91	12/31/91	1.3244	0.9894
360010	01/01/91	12/31/91	1.1637	0.9729
360012	01/01/91	12/31/91	1.2956	0.9808
360013	01/01/91	12/31/91	1.0928	0.9735
360015	01/01/91	12/31/91	1.4545	0.9982
360016	01/01/91	12/31/91	1.4854	0.9990
360018	01/01/91	12/31/91	1.3809	0.9990
360019	01/01/91	12/31/91	1.1824	0.9866
360020	01/01/91	12/31/91	1.2523	0.9936
360021	01/01/91	12/31/91	1.1998	0.9893
360024	01/01/91	12/31/91	1.2610	0.9914
360025	01/01/91	12/31/91	1.2159	0.9846
360026	01/01/91	12/31/91	1.1348	0.9921
360027	01/01/91	12/31/91	1.5200	0.9977
360030	01/01/91	12/31/91	1.1521	0.9766
360032	01/01/91	12/31/91	1.1268	0.9772
360034	01/01/91	12/31/91	1.0958	0.9472
360036	01/01/91	12/31/91	1.1847	0.9807
360037	01/01/91	12/31/91	1.8629	0.9904
360038	01/01/91	12/31/91	1.4772	0.9975
360039	01/01/91	12/31/91	1.2374	0.9932
360041	01/01/91	12/31/91	1.2398	0.9926
360042	01/01/91	12/31/91	1.0810	0.9566
360044	01/01/91	12/31/91	1.1141	0.9744
360045	01/01/90	08/31/91	1.4509	0.9966
360046	01/01/91	12/31/91	1.1344	0.9790
360047	01/01/91	12/31/91	1.1075	0.9741
360049	01/01/91	12/31/91	1.2513	0.9919
360050	01/01/91	12/31/91	1.2033	0.9660
360051	01/01/91	12/31/91	1.4573	0.9974
360055	01/01/91	12/31/91	1.1903	0.9908
360056	01/01/91	12/31/91	1.3094	0.9888
360057	01/01/91	12/31/91	0.9635	0.9687
360059	01/01/91	12/31/91	1.4728	0.9943
360061	01/01/91	12/31/91	1.1965	1.0000
360063	01/01/91	12/31/91	1.0440	0.9719
360064	01/01/91	12/31/91	1.4653	0.9971
360065	01/01/91	12/31/91	1.1896	0.9816
360066	01/01/91	12/31/91	1.2372	0.9899
360067	01/01/91	12/31/91	1.1249	0.9723
360068	01/01/91	12/31/91	1.4608	0.9977
360069	01/01/91	12/31/91	1.0494	0.9662
360070	01/01/91	12/31/91	1.4329	0.9917
360071	01/01/91	12/31/91	1.2858	0.9795
360072	01/01/91	12/31/91	1.1634	0.9724
360074	10/01/90	09/30/91	1.3164	0.9944
360075	01/01/91	12/31/91	1.4103	0.9940
360076	01/01/91	12/31/91	1.2503	0.9883
360077	01/01/91	12/31/91	1.4076	0.9968
360078	01/01/91	12/31/91	1.3057	0.9865
360079	01/01/91	12/31/91	1.6483	0.9984
360080	01/01/91	12/31/91	1.2267	0.9913
360081	01/01/91	12/31/91	1.3116	0.9970
360082	01/01/91	12/31/91	1.3121	0.9897
360083	01/01/91	12/31/91	1.2053	0.9893

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
360084	01/01/91	12/31/91	1.4184	0.9950
360086	01/01/91	12/31/91	1.3178	0.9916
360087	01/01/91	12/31/91	1.3168	0.9887
360088	01/01/91	12/31/91	1.1471	0.9736
360089	01/01/91	12/31/91	1.1064	0.9826
360091	01/01/91	12/31/91	1.3101	0.9872
360092	01/01/91	12/31/91	1.1503	0.9684
360093	01/01/91	12/31/91	1.2105	0.9720
360094	01/01/91	12/31/91	1.2387	0.9980
360095	01/01/91	12/31/91	1.2884	0.9839
360096	01/01/91	12/31/91	1.1105	0.9861
360098	01/01/91	12/31/91	1.3091	0.9693
360099	10/01/90	09/30/91	1.0405	0.9751
360100	01/01/91	12/31/91	1.2768	0.9889
360101	01/01/91	12/31/91	1.6186	0.9952
360102	01/01/91	12/31/91	1.2469	0.9957
360103	01/01/91	12/31/91	1.3518	0.9974
360104	01/01/91	12/31/91	0.9000	0.9954
360106	01/01/91	12/31/91	1.1242	0.9621
360107	09/01/90	08/31/91	1.2023	0.9680
360108	01/01/91	12/31/91	1.0197	0.9684
360109	01/01/91	12/31/91	1.0426	0.9691
360112	01/01/91	12/31/91	1.6215	0.9981
360113	01/01/91	12/31/91	1.2377	0.9929
360114	01/01/91	12/31/91	1.0423	0.9761
360115	01/01/91	12/31/91	1.2475	0.9901
360116	01/01/91	12/31/91	1.0458	0.9615
360118	01/01/91	12/31/91	1.2714	0.9856
360119	01/01/91	12/31/91	1.2327	0.9918
360120	01/01/91	12/31/91	0.5370	1.0000
360121	10/01/90	09/30/91	1.1904	0.9843
360122	01/01/91	12/31/91	1.2472	0.9905
360123	01/01/91	12/31/91	1.1627	0.9928
360124	01/01/91	12/31/91	1.2223	0.9788
360125	01/01/91	12/31/91	1.0769	0.9777
360126	01/01/91	12/31/91	1.2292	0.9897
360127	01/01/91	12/31/91	1.0349	0.9690
360128	01/01/91	12/31/91	1.0575	0.9788
360129	01/01/91	12/31/91	1.0374	0.9506
360130	01/01/91	12/31/91	1.1056	0.9841
360131	01/01/91	12/31/91	1.2531	0.9889
360132	01/01/91	12/31/91	1.1616	0.9843
360133	01/01/91	12/31/91	1.3247	0.9951
360135	01/01/91	12/31/91	1.0922	0.9830
360136	01/01/91	12/31/91	1.1116	0.9475
360137	01/01/91	12/31/91	1.5101	0.9987
360139	01/01/91	12/31/91	1.0720	0.9677
360140	01/01/91	12/31/91	1.0483	0.9828
360141	01/01/91	12/31/91	1.4184	0.9977
360142	01/01/91	12/31/91	0.9963	0.9552
360143	01/01/91	12/31/91	1.2329	0.9939
360144	01/01/91	12/31/91	1.2822	0.9921
360145	01/01/91	12/31/91	1.5243	0.9971
360147	10/01/90	09/30/91	1.2249	0.9680
360148	01/01/91	12/31/91	1.2000	0.9751
360149	01/01/91	12/31/91	1.1031	0.9899
360150	01/01/91	12/31/91	1.2363	0.9845
360151	01/01/91	12/31/91	1.3006	0.9941
360152	01/01/91	12/31/91	1.5025	0.9976
360153	01/01/91	12/31/91	1.1381	0.9887
360154	01/01/91	12/31/91	1.0700	0.9760
360155	01/01/91	12/31/91	1.2207	0.9966
360156	10/01/90	09/30/91	1.1352	0.9766
360159	01/01/91	12/31/91	1.1406	0.9708
360162	01/01/91	12/31/91	1.2472	0.9928
360163	01/01/91	12/31/91	1.6391	0.9970
360164	01/01/91	12/31/91	0.9701	0.9874
360165	11/01/90	10/31/91	1.0911	0.9822
360166	01/01/91	12/31/91	0.9723	0.9934
360169	01/01/91	12/31/91	1.0188	0.9558
360170	01/01/91	12/31/91	1.1666	0.9808
360172	01/01/91	12/31/91	1.3425	0.9865
360174	01/01/91	12/31/91	1.1711	0.9892
360175	01/01/91	12/31/91	1.1311	0.9756
360176	01/01/91	12/31/91	1.1512	0.9618
360177	01/01/91	12/31/91	1.1965	0.9624
360179	12/30/90	12/28/91	1.2456	0.9968

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
360180	01/01/91	12/31/91	2.1171	0.9887
360184	01/01/91	12/31/91	0.7143	0.9778
360186	01/01/91	12/31/91	1.1444	0.9626
360188	01/01/91	12/31/91	1.0064	0.9612
360189	01/01/91	12/31/91	1.0439	0.9870
360192	01/01/91	12/31/91	1.2811	0.9940
360193	01/01/91	12/31/91	1.2682	0.9923
360194	10/01/90	09/30/91	1.0657	0.9826
360195	01/01/91	12/31/91	1.2155	0.9577
360197	01/01/91	12/31/91	1.1790	0.9537
360200	01/01/91	12/31/91	1.1631	0.9825
360203	01/01/91	12/31/91	1.1251	0.9740
360204	01/01/91	12/31/91	1.1855	0.9888
360210	01/01/91	12/31/91	1.1895	0.9730
360211	01/01/91	12/31/91	1.1698	0.9909
360212	01/01/91	12/31/91	1.4148	0.9965
360213	01/01/91	12/31/91	1.0878	0.9879
360218	01/01/91	12/31/91	1.2981	0.9858
360230	01/01/91	12/31/91	1.3032	0.9915
360231	01/01/91	12/31/91	1.1291	0.9657
360232	01/01/91	12/31/91	1.1424	0.9770
360234	01/01/91	12/31/91	1.2469	0.9937
360236	01/01/91	12/31/91	1.1986	0.9864
360239	01/01/91	12/31/91	1.2010	0.9838
360240	01/01/91	12/31/91	0.5534	1.0000
360241	01/01/91	12/31/91	0.6349	1.0000
370001	01/01/91	12/31/91	1.6645	0.9981
370002	01/01/91	12/31/91	1.2051	0.9815
370006	10/01/90	09/30/91	1.2104	0.9897
370007	01/01/91	12/31/91	1.1412	0.9660
370014	10/01/90	09/30/91	1.1519	0.9821
370017	01/01/91	12/31/91	0.9980	0.9560
370018	11/01/90	10/31/91	1.1852	0.9883
370020	10/01/90	09/30/91	1.2597	0.9830
370021	09/01/90	08/31/91	0.9662	0.9617
370025	10/01/90	09/30/91	1.3097	0.9902
370032	11/01/90	10/31/91	1.3385	0.9973
370033	10/01/90	09/30/91	1.2096	0.9894
370037	01/01/91	12/31/91	1.5410	0.9981
370039	11/01/90	10/31/91	1.2375	0.9781
370040	10/01/90	09/30/91	1.0307	0.9695
370049	01/01/91	12/31/91	1.2992	0.9751
370051	10/01/90	09/30/91	0.9755	0.9678
370054	01/01/91	12/31/91	1.2703	0.9823
370057	01/01/91	12/31/91	1.0796	0.9662
370071	07/01/90	12/31/91	1.0037	0.9662
370077	01/01/91	12/31/91	1.1983	0.9912
370078	01/01/91	12/31/91	1.5209	0.9993
370092	10/01/90	09/30/91	1.0339	0.9472
370093	09/01/90	08/31/91	1.6126	0.9983
370094	01/01/91	12/31/91	1.2836	0.9975
370095	01/01/91	12/31/91	0.8996	0.9650
370105	10/01/90	09/30/91	1.8890	0.9941
370108	11/01/90	10/31/91	1.3356	0.9995
370109	10/01/90	09/30/91	1.0337	0.9744
370114	10/01/90	09/30/91	1.5430	0.9994
370117	10/01/90	10/20/91	1.3104	0.9895
370121	09/01/90	08/31/91	1.1812	0.9723
370141	09/01/90	08/31/91	1.4333	0.9961
370148	01/01/91	12/31/91	1.0293	0.9819
370149	09/01/90	08/31/91	1.2728	0.9887
370149	10/01/90	09/30/91	1.2142	0.9781
370157	10/01/90	09/30/91	0.9177	0.9555
370161	11/01/90	10/31/91	1.1359	0.9656
370165	10/01/90	09/30/91	1.1678	0.9866
370169	01/01/91	12/31/91	1.0252	0.9602
370176	01/01/91	12/31/91	1.2606	0.9815
370177	01/01/91	12/31/91	0.9454	0.9689
370179	10/01/90	09/30/91	1.0758	0.9290
370189	01/01/91	12/31/91	0.9631	0.9823
380004	01/01/91	12/31/91	1.8075	0.9804
380006	01/01/91	12/31/91	1.2208	0.9778
380010	01/01/91	12/31/91	1.1584	0.9795
380014	01/01/91	12/31/91	1.3162	0.9788
380018	10/01/90	09/30/91	1.8719	0.9977
380019	01/01/91	12/31/91	1.2112	0.9922
380020	10/01/90	09/30/91	1.3492	0.9836

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
380021	10/01/90	09/30/91	1.2308	0.9906
380022	10/01/90	09/30/91	1.2365	0.9823
380026	01/01/91	12/31/91	1.4080	0.9554
380029	10/01/90	09/30/91	1.1623	0.9595
380036	01/01/91	12/31/91	1.0743	0.9431
380038	08/01/90	07/31/91	1.2550	0.9751
380039	01/01/91	12/31/91	1.3001	0.9893
380042	01/01/91	12/31/91	1.0988	0.9678
380047	01/01/91	12/31/91	1.5499	0.9994
380050	10/01/90	09/30/91	1.3313	0.9841
380051	10/01/90	09/30/91	1.4276	0.9930
380052	01/01/91	12/31/91	1.1835	0.9786
380055	01/01/91	12/31/91	1.1800	0.9903
380056	01/01/91	12/31/91	1.0506	0.9654
380059	07/01/90	07/31/91	0.9216	0.9662
380060	01/01/91	12/31/91	1.3427	0.9912
380061	01/01/91	12/31/91	1.6171	0.9980
380064	08/01/90	07/31/91	1.3093	0.9890
380068	10/01/90	09/30/91	1.0739	0.9600
380070	01/01/91	12/31/91	1.0567	0.9585
380075	01/01/91	12/31/91	1.3789	0.9916
380082	01/01/91	12/31/91	1.2801	0.9895
380091	01/01/91	12/31/91	1.1475	0.9866
390028	01/01/91	12/31/91	1.7001	0.9976
390054	01/01/91	12/31/91	1.1090	0.9820
390060	01/01/91	12/31/91	1.1547	0.9892
390128	01/01/91	12/31/91	1.1854	0.9916
390169	01/01/91	12/31/91	1.2253	0.9975
390186	01/01/91	12/31/91	1.1687	0.9810
390224	10/01/90	09/30/91	0.9582	0.9775
390237	01/01/91	12/31/91	1.4831	0.9977
400002	01/01/91	12/31/91	1.2248	0.9990
400005	01/01/91	12/31/91	1.0805	0.9997
400007	01/01/91	12/31/91	1.1059	0.9989
400008	01/01/91	12/31/91	1.1672	0.9980
400010	10/01/90	09/30/91	0.9643	0.9905
400011	01/01/91	12/31/91	1.0816	0.9961
400014	01/01/91	12/31/91	1.3134	0.9986
400016	10/01/90	09/30/91	1.2611	0.9994
400017	01/01/91	12/31/91	1.1175	0.9976
400019	01/01/91	12/31/91	1.4370	0.9988
400022	01/01/91	12/31/91	1.2916	0.9998
400024	01/01/91	12/31/91	1.0561	0.9987
400029	07/01/90	08/31/91	1.0231	0.9967
400032	01/01/91	12/31/91	1.1341	0.9981
400089	01/01/91	12/31/91	1.0793	0.9968
400094	01/01/91	12/31/91	0.9243	0.9934
400098	01/01/91	12/31/91	1.2146	0.9987
400106	10/01/90	09/30/91	1.1439	0.9978
400109	10/01/90	09/30/91	1.4983	0.9997
400111	01/01/91	12/31/91	1.2501	0.9976
400112	09/01/90	08/31/91	1.2031	0.9959
400113	10/01/90	09/30/91	1.1983	0.9987
400115	01/01/91	12/31/91	1.0223	0.9944
400117	01/01/91	12/31/91	1.1765	0.9976
400118	1/01/91	12/31/91	1.1673	0.9979
400120	11/01/91	12/31/91	1.2988	0.9994
410001	10/01/90	09/30/91	1.2662	0.9921
410002	10/01/90	09/30/91	1.2509	0.9904
410004	10/01/90	09/30/91	1.4269	0.9940
410005	10/01/90	09/30/91	1.2986	0.9964
410006	10/01/90	09/30/91	1.1891	0.9903
410007	10/01/90	09/30/91	1.5203	0.9980
410008	10/01/90	09/30/91	1.1992	0.9802
410009	10/01/90	09/30/91	1.3381	0.9947
410010	10/01/90	09/30/91	1.0294	0.9872
410011	10/01/90	09/30/91	1.1919	0.9932
410012	10/01/90	09/30/91	1.5865	0.9979
410013	10/01/90	09/30/91	1.1509	0.9835
420005	01/01/91	12/31/91	1.0876	0.9793
420007	09/23/90	10/05/91	1.4065	0.9989
420009	10/01/90	09/30/91	1.2309	0.9622
420010	10/01/90	09/30/91	1.0721	0.9530
420011	10/01/90	09/30/91	1.0839	0.9713
420014	10/01/90	09/30/91	1.1135	0.9763
420015	10/01/90	09/30/91	1.2546	0.9842
420016	10/01/90	09/30/91	1.2158	0.9845

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
420018	09/30/90	09/28/91	1.6263	0.9957
420019	10/01/90	09/30/91	1.1680	0.9761
420020	10/01/90	09/30/91	1.1754	0.9761
420022	09/23/90	10/05/91	0.9958	0.9743
420023	01/01/91	12/31/91	1.2720	0.9952
420026	09/09/90	09/07/91	1.7991	0.9975
420027	09/30/90	09/28/91	1.3436	0.9891
420028	10/01/90	09/30/91	1.0488	0.9657
420029	10/01/90	09/30/91	1.8435	1.0000
420030	01/01/91	12/31/91	1.1872	0.9583
420031	10/01/90	09/30/91	0.9742	0.9319
420033	10/01/90	09/30/91	1.1675	0.9811
420036	10/01/90	09/30/91	1.2538	0.9828
420037	10/01/90	09/30/91	1.2815	0.9708
420038	10/01/90	09/30/91	1.2053	0.9692
420039	10/01/90	09/30/91	1.1185	0.9800
420040	10/01/90	09/30/91	1.3052	0.9952
420042	10/01/90	09/30/91	1.0814	0.9814
420043	10/01/90	09/30/91	1.1441	0.9748
420044	10/01/90	09/30/91	1.1474	0.9901
420048	10/01/90	09/30/91	1.1336	0.9657
420049	10/01/90	09/30/91	1.0915	0.9767
420051	10/01/90	09/30/91	1.5379	0.9979
420054	09/01/90	08/31/91	1.1393	0.9583
420055	10/01/90	09/30/91	1.0306	0.9841
420056	10/01/90	09/30/91	1.0070	0.9070
420057	10/01/90	09/30/91	1.0066	0.9748
420059	10/01/90	09/30/91	1.0510	0.9601
420061	10/01/90	09/30/91	1.2715	0.9562
420064	10/01/90	09/30/91	1.0773	0.9836
420066	10/01/90	09/30/91	0.9927	0.9472
420067	10/01/90	09/30/91	1.1022	0.9549
420068	10/01/90	09/30/91	1.1764	0.9908
420069	10/01/90	09/30/91	1.0010	0.9458
420070	10/01/90	09/30/91	1.2662	0.9781
420071	10/01/90	09/30/91	1.3715	0.9914
420072	10/01/90	09/30/91	1.0016	0.9724
420073	10/01/90	09/30/91	1.2818	0.9874
420074	10/01/90	09/30/91	0.9675	0.9484
420075	10/01/90	09/30/91	1.0723	0.9838
420076	01/01/91	12/31/91	1.2336	0.9956
420078	10/01/90	09/30/91	1.5706	0.9981
420081	10/01/90	09/30/91	0.7937	0.9714
420086	10/01/90	09/30/91	1.3756	0.9930
420087	10/01/90	09/30/91	1.5223	0.9985
420088	10/01/90	09/30/91	1.1815	0.9887
420089	09/01/90	08/31/91	1.2692	0.9879
430008	01/01/91	12/31/91	1.2104	0.9812
430009	01/01/91	12/31/91	0.9819	0.9494
430013	10/01/90	09/30/91	1.2429	0.9828
430014	10/01/90	09/30/91	1.1908	0.9831
430015	08/01/90	07/31/91	1.0321	0.9783
430016	10/01/90	09/30/91	1.7031	0.9977
430017	01/01/90	12/18/91	1.0902	0.9814
430023	09/01/90	08/31/91	0.9512	0.9729
430024	01/01/91	12/31/91	1.0153	0.9517
430026	01/01/91	12/31/91	0.8874	0.9570
430028	01/01/91	12/31/91	1.0921	0.9863
430029	09/01/90	08/31/91	0.9991	0.9692
430031	01/01/91	12/31/91	0.9924	0.9631
430034	01/01/91	12/31/91	1.0600	1.0000
430036	01/01/91	12/31/91	1.0445	0.9820
430038	01/01/91	12/31/91	1.0571	0.9916
430040	10/01/90	09/30/91	0.9194	0.9812
430041	01/01/91	12/31/91	0.9497	0.9491
430043	01/01/91	12/31/91	1.1726	0.9900
430044	01/01/91	12/31/91	0.9371	0.9726
430047	01/01/91	12/31/91	1.1379	0.9663
430048	01/01/91	12/31/91	1.1525	0.9850
430049	01/01/91	12/31/91	0.9244	0.9562
430051	01/01/91	12/31/91	0.9945	0.9335
430056	01/01/91	12/31/91	0.8854	0.9406
430057	01/01/91	12/31/91	0.9508	0.9778
430060	01/01/91	12/31/91	1.0189	0.9053
430064	12/01/90	11/30/91	1.0512	0.9711
430065	10/01/90	09/30/91	0.9439	0.9233
430073	10/01/90	09/30/91	1.1114	0.9949

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
430076	01/01/91	12/31/91	0.9984	0.9794
430079	01/01/91	12/31/91	1.0127	0.9897
430080	10/01/90	09/30/91	0.8204	1.0000
430087	01/01/91	12/31/91	1.0659	0.9661
430088	01/01/91	12/31/91	0.9353	0.9770
440008	01/01/91	12/31/91	0.9674	0.9628
440018	11/01/90	10/31/91	1.3078	0.9707
440020	09/01/90	09/29/91	1.2123	0.9702
440026	09/01/90	09/30/91	1.2592	0.9827
440034	01/01/91	12/31/91	1.3929	0.9867
440046	01/01/91	12/31/91	1.0276	0.9957
440047	09/01/90	08/31/91	0.9033	0.9687
440048	10/01/90	09/30/91	1.5925	0.9975
440049	01/01/91	12/31/91	1.6117	0.9990
440050	01/01/91	12/31/91	1.1605	0.9870
440058	01/01/91	12/31/91	1.1819	0.9729
440061	10/01/90	09/30/91	1.1047	0.9703
440064	01/01/91	12/31/91	1.1236	0.9680
440067	09/01/90	08/31/91	1.1662	0.9680
440068	10/01/90	09/30/91	1.1649	0.9750
440071	01/01/91	12/31/91	1.3317	0.9984
440072	01/01/91	12/31/91	1.3975	0.9652
440078	10/01/90	09/30/91	1.0118	0.9811
440079	01/01/91	12/31/91	0.8359	0.9666
440081	01/01/91	12/31/91	1.1793	0.9756
440083	01/01/91	12/31/91	1.2345	0.9794
440087	01/01/91	12/31/91	0.9950	0.9478
440091	09/01/90	08/31/91	1.3908	0.9988
440095	01/01/91	12/31/91	1.0625	0.9706
440100	01/01/91	12/31/91	1.0898	0.9626
440110	01/01/91	12/31/91	1.0966	0.9636
440120	01/01/91	12/31/91	1.4435	0.9990
440125	01/01/91	12/31/91	1.4546	0.9990
440136	09/01/90	08/31/91	1.2368	0.9825
440145	11/01/89	09/30/91	0.9976	0.9586
440146	01/01/91	12/31/91	1.2639	0.9750
440148	01/01/91	12/31/91	1.1627	0.9693
440149	11/01/90	10/31/91	1.1682	0.9742
440150	01/01/91	12/31/91	1.3003	0.9909
440157	01/01/91	12/31/91	0.9953	0.9833
440161	01/01/91	12/31/91	1.5728	0.9979
440168	01/01/91	12/31/91	1.0236	0.9545
440174	01/01/91	12/31/91	0.9155	0.9458
440178	09/01/90	08/31/91	1.1862	0.9873
440181	01/01/91	12/31/91	1.0171	0.9583
440182	01/01/91	12/31/91	0.9260	0.9503
440184	01/01/91	12/31/91	1.2642	0.9883
440185	09/01/90	08/31/91	1.0551	0.9876
440186	11/01/90	10/31/91	1.1406	0.9551
440189	08/01/90	07/31/91	1.4639	0.9927
440194	09/01/90	08/31/91	1.2402	0.9823
440196	01/01/91	12/31/91	0.9593	0.9708
440200	12/01/90	11/30/91	1.0918	0.9560
440203	01/01/91	12/31/91	0.9910	0.9800
440205	01/01/91	12/31/91	0.9641	0.9783
450002	01/01/91	12/31/91	1.4287	0.9987
450005	09/01/90	08/31/91	1.0257	0.9776
450010	10/01/90	09/30/91	1.2778	0.9942
450011	01/01/91	12/31/91	1.5650	0.9980
450014	01/01/91	12/31/91	1.1148	0.9658
450015	10/01/90	09/30/91	1.5148	0.9990
450016	01/01/91	12/31/91	1.6676	0.9975
450018	09/01/90	08/31/91	1.6354	0.9989
450020	01/01/91	12/31/91	1.0695	0.9606
450024	10/01/90	09/30/91	1.2745	0.9932
450025	01/01/91	12/31/91	1.4745	0.9953
450028	01/01/91	12/31/91	1.4051	0.9935
450032	10/01/90	09/30/91	1.2141	0.9746
450033	09/01/90	08/31/91	1.6021	0.9993
450037	10/01/90	09/30/91	1.4613	0.9978
450039	10/01/90	09/30/91	1.1669	0.9987
450041	01/01/91	12/31/91	0.9680	0.9505
450043	01/01/90	10/04/91	1.4065	0.9983
450046	01/01/90	09/30/91	1.4016	0.9972
450047	10/01/90	09/30/91	1.0057	0.9721
450050	01/01/91	12/31/91	1.2977	0.9671
450053	01/01/91	12/31/91	1.1278	0.9389

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450054	09/01/90	08/31/91	1.6250	0.9982
450055	10/01/90	09/30/91	1.0724	0.9639
450057	07/04/90	11/26/91	1.2081	0.9917
450058	09/01/90	08/31/91	1.5007	0.9987
450059	01/01/91	12/31/91	1.3316	0.9749
450063	10/01/90	09/30/91	0.9350	0.9435
450065	10/01/90	09/30/91	1.1409	0.9734
450068	10/01/90	09/30/91	1.6478	0.9976
450072	01/01/91	12/31/91	1.1702	0.9610
450073	01/01/91	12/31/91	1.1079	0.9608
450076	09/01/90	08/31/91	1.2329	0.9999
450077	10/01/90	09/30/91	0.9717	0.9851
450080	10/01/90	09/30/91	1.1683	0.9744
450081	01/01/91	12/31/91	1.2080	0.9780
450082	10/01/90	09/30/91	0.9919	0.9456
450083	11/01/90	10/31/91	1.5629	0.9917
450085	10/01/90	09/30/91	0.9964	0.9787
450087	09/01/90	08/31/91	1.3355	0.9864
450094	01/01/91	12/31/91	1.3867	0.9948
450097	01/01/91	12/31/91	1.4069	0.9919
450098	11/01/90	10/31/91	1.1282	0.9799
450101	09/01/90	08/31/91	1.3795	0.9983
450104	01/01/91	12/31/91	1.2224	0.9712
450107	01/01/91	12/31/91	1.4521	0.9986
450108	10/01/90	09/30/91	0.9627	0.9495
450110	10/01/90	09/30/91	1.2206	0.9950
450112	01/01/91	12/31/91	1.2484	0.9849
450118	09/01/90	08/31/91	1.4270	0.9988
450119	10/01/90	09/30/91	1.2430	0.9817
450121	10/01/90	09/30/91	1.3732	0.9920
450123	05/01/90	12/31/91	1.0563	0.9819
450124	10/01/90	09/30/91	1.4619	0.9992
450127	10/01/90	09/30/91	0.9736	0.9496
450130	01/01/91	12/31/91	1.4751	0.9990
450131	08/01/90	07/31/91	1.2383	0.9888
450132	10/01/90	09/30/91	1.4472	0.9962
450133	10/01/90	09/30/91	1.4367	0.9967
450135	10/01/90	09/30/91	1.5550	0.9974
450137	10/01/90	09/30/91	1.3443	0.9949
450140	10/01/90	09/30/91	0.9001	0.9352
450142	09/01/90	08/31/91	1.2780	0.9875
450144	10/01/90	09/30/91	1.1362	0.9725
450145	01/01/91	12/31/91	0.9849	0.9678
450146	10/01/90	09/30/91	1.0151	0.9484
450148	10/01/90	09/30/91	1.3142	0.9798
450149	11/01/90	10/31/91	1.3871	0.9950
450150	10/01/90	09/30/91	1.0018	0.9409
450151	10/01/90	09/30/91	1.0753	0.9773
450152	10/01/90	09/30/91	1.4101	0.9954
450153	01/01/91	12/31/91	1.5958	0.9989
450154	10/01/90	09/30/91	1.1204	0.9645
450155	10/01/90	09/30/91	1.0537	0.9759
450160	10/01/90	09/30/91	1.0303	0.9536
450162	09/01/90	09/29/91	1.3480	0.9853
450163	01/01/91	12/31/91	1.1154	0.9678
450164	10/01/90	09/30/91	0.9316	0.9597
450165	01/01/91	12/31/91	0.9464	0.9888
450166	01/01/91	12/31/91	0.8739	0.9885
450169	01/01/91	12/31/91	0.8471	0.9495
450175	01/01/90	09/30/91	1.2209	0.9791
450176	10/01/90	09/30/91	1.2811	0.9733
450178	01/01/91	12/31/91	1.0877	0.9553
450181	01/01/91	12/31/91	1.0169	0.9702
450185	10/01/90	09/30/91	1.0490	0.8945
450187	01/01/91	12/31/91	1.2248	0.9819
450191	01/01/91	12/31/91	1.1094	0.9761
450192	09/01/90	08/31/91	1.1054	0.9823
450193	10/01/90	09/30/91	2.1579	0.9989
450194	01/01/91	12/31/91	1.1427	0.9873
450195	01/01/91	12/31/91	1.3861	0.9790
450196	01/01/91	12/31/91	1.2515	0.9873
450197	09/01/90	08/31/91	1.2111	0.9914
450200	10/01/90	09/30/91	1.2927	0.9960
450201	01/01/91	12/31/91	0.9547	0.9516
450203	10/01/90	09/30/91	1.1623	0.9910
450209	10/01/90	09/30/91	1.3431	0.9924
450210	01/01/91	12/31/91	1.1553	0.9588

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450211	01/01/91	12/31/91	1.2503	0.9929
450213	01/01/91	12/31/91	1.4458	0.9932
450214	09/01/90	08/31/91	1.3040	0.9729
450218	10/01/89	07/08/91	0.9753	0.9627
450224	10/01/90	09/30/91	1.1294	0.9688
450229	09/01/90	08/31/91	1.3647	0.9893
450231	01/01/91	12/31/91	1.5913	0.9981
450234	10/01/90	09/30/91	0.9360	0.9254
450236	10/01/90	09/30/91	1.1319	0.9844
450237	01/01/91	12/31/91	1.5122	0.9975
450239	08/01/90	07/31/91	1.1595	0.9645
450243	09/01/90	08/31/91	0.9226	0.9676
450246	10/01/90	09/30/91	0.9865	0.9453
450253	01/01/91	12/31/91	1.0854	0.9828
450259	01/01/91	12/31/91	1.2132	0.9888
450264	10/01/90	09/30/91	0.8622	0.9733
450271	01/01/91	12/31/91	1.2010	0.9700
450272	01/01/91	12/31/91	1.3414	0.9712
450276	10/01/90	09/30/91	0.9944	0.9644
450280	01/01/91	12/31/91	1.3219	0.9951
450283	11/01/90	10/31/91	1.1408	0.9429
450286	01/01/91	12/31/91	1.0929	0.9818
450292	10/01/90	09/30/91	1.2528	0.9766
450293	01/01/91	12/31/91	1.0120	0.9524
450296	01/01/91	12/31/91	1.1909	0.9711
450297	01/01/91	12/31/91	1.0831	0.9934
450299	09/01/90	08/31/91	1.3598	0.9832
450303	01/01/91	12/31/91	0.9492	0.9543
450306	01/01/91	12/31/91	1.0313	0.9368
450315	09/01/90	08/31/91	1.2251	0.9959
450321	01/01/91	12/31/91	0.8468	0.9630
450322	01/01/91	12/31/91	0.9284	0.9381
450327	10/01/90	09/30/91	0.9950	0.9573
450334	10/01/90	09/30/91	1.0743	0.9830
450337	11/01/90	10/31/91	1.1766	0.9809
450340	01/01/91	12/31/91	1.3383	0.9873
450346	09/01/90	08/31/91	1.3163	0.9968
450347	01/01/91	12/31/91	1.2101	0.9790
450348	09/01/90	08/31/91	0.9825	0.9594
450352	10/01/90	09/30/91	1.2137	0.9610
450353	09/01/90	08/31/91	1.1378	0.9606
450355	08/01/90	07/31/91	1.0480	0.9195
450358	01/01/91	12/31/91	1.9932	0.9988
450365	01/01/91	12/31/91	0.9500	0.9944
450369	10/01/90	09/30/91	1.2014	0.9508
450371	01/01/91	12/31/91	1.1331	0.9840
450373	11/01/90	10/31/91	1.1519	0.9702
450374	10/01/90	09/30/91	0.8627	0.9181
450376	01/01/90	09/30/91	1.4706	0.9953
450378	09/01/90	08/31/91	1.3133	0.9826
450388	10/01/90	09/30/91	1.6332	0.9991
450389	11/01/90	10/31/91	1.2225	0.9857
450399	10/01/90	09/30/91	1.0342	0.9692
450403	10/01/90	09/30/91	1.2076	0.9891
450410	01/01/90	11/10/91	1.0733	0.9891
450417	01/01/91	12/31/91	1.0491	0.9237
450419	10/01/90	09/30/91	1.2507	0.9894
450422	10/01/90	09/30/91	0.7583	1.0000
450423	09/01/90	08/31/91	1.3829	0.9960
450424	01/01/91	12/31/91	1.2943	0.9780
450429	12/01/90	11/30/91	0.9101	0.9603
450431	01/01/91	12/31/91	1.5383	0.9975
450438	01/01/91	12/31/91	1.0401	0.9578
450446	01/01/91	12/31/91	0.8818	0.9682
450450	10/01/90	09/30/91	1.0881	0.9777
450462	10/01/90	09/30/91	1.5907	0.9986
450464	10/01/90	09/30/91	0.9141	0.9752
450465	10/01/90	09/30/91	1.1021	0.9778
450475	10/01/90	09/30/91	1.1378	0.9837
450488	10/01/90	09/30/91	1.2064	0.9643
450514	01/01/91	12/31/91	1.1361	0.9827
450518	01/01/91	12/31/91	1.3095	0.9959
450523	01/01/91	12/31/91	1.5068	0.9919
450530	12/01/90	11/30/91	1.2867	0.9954
450534	10/01/90	09/30/91	0.9602	0.9588
450535	01/01/91	12/31/91	1.2130	0.9880
450538	01/01/91	12/31/91	1.2380	0.9809

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450539	09/01/90	09/29/91	1.2853	0.9570
450544	08/01/90	07/31/91	1.2416	0.9934
450547	10/01/90	09/30/91	0.9701	0.9705
450550	01/01/91	12/31/91	1.0519	0.9939
450558	09/01/90	08/31/91	1.7904	0.9966
450559	10/01/90	09/30/91	0.8843	0.9789
450561	10/01/90	09/30/91	1.5108	0.9979
450565	10/01/90	09/30/91	1.2898	0.9839
450571	10/01/90	09/30/91	1.4391	0.9986
450574	10/01/90	09/30/91	1.0266	0.9367
450575	10/01/90	09/30/91	0.9916	0.9894
450578	10/01/90	09/30/91	0.9534	0.9568
450580	10/01/90	09/30/91	1.1794	0.9815
450583	10/01/90	09/30/91	1.0084	0.9895
450584	10/01/90	09/30/91	1.1806	0.9695
450587	09/01/90	08/31/91	1.2459	0.9828
450591	10/01/90	09/30/91	1.2403	0.9759
450596	10/01/90	09/30/91	1.2377	0.9776
450597	10/01/90	09/30/91	1.0338	0.9710
450604	01/01/91	12/31/91	1.2403	0.9776
450605	01/01/91	12/31/91	1.2221	0.9654
450607	10/01/90	09/30/91	0.9056	0.9370
450609	10/01/90	09/30/91	0.8575	0.9792
450614	10/01/90	09/30/91	1.0172	0.9355
450615	01/01/91	12/31/91	0.9560	0.9603
450617	09/01/90	08/31/91	1.3755	0.9956
450620	07/01/90	09/30/91	1.0837	0.9294
450623	10/01/90	09/30/91	1.1524	0.9746
450626	10/01/90	09/30/91	0.9541	0.9173
450628	10/01/90	09/30/91	0.9605	0.9701
450631	09/01/90	08/31/91	1.6431	0.9975
450632	10/01/90	09/30/91	0.9911	0.9683
450633	09/01/90	08/31/91	1.5670	0.9972
450634	01/01/91	12/31/91	1.3617	0.9933
450637	09/01/90	08/31/91	1.3126	0.9793
450639	10/01/90	09/30/91	1.5123	0.9978
450644	09/01/90	08/31/91	1.5941	0.9957
450646	01/01/91	12/31/91	1.4885	0.9960
450647	09/01/90	08/31/91	1.9489	0.9990
450648	10/01/90	09/30/91	1.1052	0.9818
450652	10/01/90	09/30/91	0.9360	0.9419
450653	08/01/90	07/31/91	1.2340	0.9844
450654	10/01/90	09/30/91	0.9855	0.9915
450656	01/01/91	12/31/91	1.2559	0.9920
450659	01/01/91	12/31/91	1.4484	0.9982
450661	01/01/91	12/31/91	1.2415	0.9922
450662	09/01/90	08/31/91	1.4170	0.9900
450666	09/01/90	08/31/91	1.2138	0.9898
450669	07/01/90	07/01/91	1.2844	0.9814
450672	08/01/90	07/31/91	1.5957	0.9984
450673	10/01/90	09/30/91	1.0201	0.9685
450677	01/01/91	12/31/91	1.3292	0.9952
450683	10/01/90	09/30/91	1.2997	0.9713
450685	07/01/90	09/23/91	1.2335	0.9918
450686	12/31/90	12/31/91	1.3484	0.9936
450690	09/01/90	08/31/91	1.3215	0.9957
450696	11/01/90	10/31/91	1.1030	1.0000
450697	01/01/91	12/31/91	1.4486	0.9935
450698	10/01/89	09/30/91	0.8955	0.9375
450700	01/01/91	12/31/91	0.9278	0.9510
450702	09/01/90	08/31/91	1.2830	0.9925
450703	01/01/91	12/31/91	1.3000	0.9860
450705	10/01/90	09/30/91	0.8045	0.9776
450706	01/01/91	12/31/91	1.2497	0.9750
450711	10/01/90	09/30/91	1.6238	0.9982
450712	11/01/90	10/31/91	0.7660	1.0000
450713	01/01/91	12/31/91	1.2557	0.9824
450715	09/01/90	08/31/91	1.3498	0.9939
450716	01/01/91	12/31/91	1.2058	0.9822
450717	01/01/91	12/31/91	1.1978	0.9662
450718	01/01/91	12/31/91	1.1202	0.9826
450724	01/01/91	12/31/91	1.1409	0.9954
450725	09/01/90	08/31/91	0.9157	0.9873
450726	10/01/90	09/30/91	0.8589	0.9368
450727	10/01/90	09/30/91	0.9540	0.9696
450728	10/01/90	09/30/91	0.8538	0.9113
450729	01/01/91	12/31/91	1.0063	0.9791

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450732	08/01/90	07/31/91	1.1639	0.9493
450734	09/01/90	08/31/91	1.2400	0.9915
450735	01/01/91	12/31/91	0.8527	0.9792
450742	09/01/90	12/18/91	1.3082	0.9777
450745	01/01/91	12/31/91	0.8729	0.9968
450746	10/01/90	09/30/91	0.9038	0.9070
450747	01/01/91	12/31/91	1.3262	0.9772
450751	01/01/91	12/31/91	1.3289	0.9772
450754	10/01/90	09/30/91	0.8799	0.9580
450757	01/01/91	12/31/91	0.9338	0.9108
450759	01/01/90	12/31/91	1.0712	0.9928
450760	01/01/90	12/31/91	1.2785	0.9837
450761	10/01/90	09/30/91	0.9393	0.9630
450763	10/01/90	09/30/91	1.0462	0.9475
450768	01/01/91	12/31/91	1.6546	0.9973
460001	01/01/91	12/31/91	1.6042	0.9980
460004	01/01/91	12/31/91	1.7099	0.9980
460006	01/01/91	12/31/91	1.3234	0.9860
460007	01/01/91	12/31/91	1.3637	0.9839
460010	01/01/91	12/31/91	1.9961	0.9989
460011	01/01/91	12/31/91	1.3182	0.9682
460013	09/01/90	08/31/91	1.4279	0.9937
460014	01/01/91	12/31/91	1.0365	0.8998
460015	01/01/91	12/31/91	1.2228	0.9707
460016	01/01/91	12/31/91	0.9737	0.9539
460017	09/01/90	08/31/91	1.2304	0.9794
460018	01/01/91	12/31/91	0.9520	0.9820
460019	01/01/91	12/31/91	0.9794	0.9588
460020	01/01/91	12/31/91	0.9409	0.9691
460021	01/01/91	12/31/91	1.3083	0.9905
460022	01/01/91	12/31/91	0.9658	0.9922
460023	01/01/91	12/31/91	1.0875	0.9760
460024	10/01/90	09/30/91	1.0085	0.9963
460025	01/01/91	12/31/91	0.8296	0.9868
460026	01/01/91	12/31/91	0.9268	0.9453
460027	01/01/91	12/31/91	0.9402	0.9841
460029	01/01/91	12/31/91	0.9919	0.9579
460033	01/01/91	12/31/91	0.9793	0.9021
460036	01/01/91	12/31/91	0.9487	0.9468
460039	01/01/91	12/31/91	0.9283	0.9276
460041	09/01/90	08/31/91	1.2405	0.9751
460042	10/01/90	09/30/91	1.3798	0.9854
460043	01/01/91	12/31/91	1.4477	0.8859
460044	01/01/91	12/31/91	1.1163	0.9696
460046	01/01/91	12/31/91	1.1878	0.5694
460047	11/01/90	10/31/91	1.6065	0.9986
470001	10/01/90	09/30/91	1.1566	0.9793
470003	10/01/90	09/30/91	1.9195	0.9972
470004	10/01/90	09/30/91	1.1700	0.9793
470005	10/01/90	09/30/91	1.1992	0.9909
470006	10/01/90	09/30/91	1.2789	0.9778
470008	10/01/90	09/30/91	1.2181	0.9765
470010	10/01/90	09/30/91	1.0242	0.9684
470011	10/01/90	09/30/91	1.1590	0.9848
470012	10/01/90	09/30/91	1.2581	0.9853
470013	10/01/90	09/30/91	1.1233	0.9882
470015	10/01/90	09/30/91	1.2187	0.9952
470018	10/01/90	09/30/91	1.1700	0.9701
470020	10/01/90	09/30/91	0.9983	0.9727
470023	10/01/90	09/30/91	1.2301	0.9519
470024	10/01/90	09/30/91	1.1111	0.9700
490001	10/01/90	09/30/91	1.1390	0.9847
490002	09/01/90	09/29/91	1.0256	0.9769
490003	10/01/90	09/30/91	0.6383	0.9998
490004	01/01/91	12/31/91	1.2313	0.9879
490005	01/01/91	12/31/91	1.3969	0.9956
490006	10/01/90	09/30/91	1.1331	0.9706
490008	01/01/91	12/31/91	1.1698	0.9837
490011	01/01/91	12/31/91	1.3148	0.9926
490012	08/01/90	07/31/91	1.0070	0.9636
490013	09/01/90	08/31/91	1.1266	0.9861
490014	01/01/91	12/31/91	1.5962	0.9888
490015	09/01/90	12/10/91	1.4713	0.9932
490017	09/01/90	08/31/91	1.2811	0.9862
490018	01/01/91	12/31/91	1.0957	0.9737
490019	10/01/90	09/30/91	1.1416	0.9737
490020	01/01/91	12/31/91	1.0847	0.9781

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
490021	01/01/91	12/31/91	1.3966	0.9960
490023	10/01/90	09/30/91	1.1882	0.9941
490024	10/01/90	09/30/91	1.6479	0.9982
490027	10/01/90	09/30/91	1.0299	0.9774
490030	10/01/90	09/30/91	1.3039	0.9976
490031	01/01/91	12/31/91	1.0589	0.9672
490033	01/01/91	12/31/91	1.2290	0.9809
490037	01/01/91	12/31/91	1.1280	0.9833
490038	10/01/90	09/30/91	1.2388	0.9869
490040	10/01/90	09/29/91	1.3896	0.9988
490041	01/01/91	12/31/91	1.1601	0.9881
490042	10/01/90	09/30/91	1.2789	0.9852
490044	10/01/90	09/30/91	1.2705	0.9925
490045	10/01/90	09/30/91	1.1531	0.9928
490047	10/01/90	09/30/91	1.1620	0.9840
490048	01/01/91	12/31/91	1.3588	0.9903
490050	01/01/91	12/31/91	1.3227	0.9970
490052	01/01/91	12/31/91	1.4139	0.9986
490054	10/01/90	09/30/91	1.0617	0.9695
490057	01/01/91	12/31/91	1.3604	0.9995
490059	09/01/90	08/31/91	1.4025	0.9990
490060	09/01/90	08/31/91	1.0792	0.9888
490063	01/01/91	12/31/91	1.5865	0.9983
490066	01/01/91	12/31/91	1.1257	0.9689
490067	01/01/91	12/31/91	1.2768	0.9913
490069	10/01/90	09/30/91	1.3551	0.9989
490071	01/01/91	12/31/91	1.3146	0.9943
490073	09/01/90	08/31/91	1.1743	0.9930
490074	01/01/91	12/31/91	1.2773	0.9921
490075	01/01/91	12/31/91	1.2630	0.9864
490077	10/01/90	09/30/91	1.1730	0.9942
490079	01/01/91	12/31/91	1.2537	0.9775
490083	10/01/90	09/30/91	0.7790	0.9914
490084	01/01/91	12/31/91	1.1339	0.9271
490085	10/01/90	09/30/91	1.2241	0.9701
490088	10/01/90	09/30/91	1.1262	0.9799
490089	10/01/90	09/30/91	1.0387	0.9723
490091	10/01/90	09/30/91	1.1636	0.9834
490092	01/01/91	12/31/91	1.1466	0.9766
490095	01/01/91	12/31/91	1.2779	0.9858
490097	09/01/90	08/31/91	1.1294	0.9914
490099	09/01/90	08/31/91	0.9518	0.9537
490100	10/01/90	09/30/91	1.2980	0.9969
490101	01/01/91	12/31/91	1.1204	0.9824
490107	01/01/91	12/31/91	1.2668	0.9895
490110	10/01/90	09/30/91	1.2088	0.9959
490112	09/01/90	08/31/91	1.5131	0.9981
490113	11/01/90	10/31/91	1.2327	0.9745
490115	10/01/90	09/30/91	1.1523	0.9827
490117	09/01/90	08/31/91	1.1746	0.9826
490122	12/01/90	11/30/91	1.0755	0.9840
490126	01/01/91	12/31/91	1.2187	0.9939
490129	10/01/90	09/30/91	1.1978	0.9856
490130	01/01/91	12/31/91	1.1320	1.0000
500001	01/01/91	12/31/91	1.2380	0.9794
500002	01/01/91	12/31/91	1.2970	0.9836
500003	01/01/91	12/31/91	1.4504	0.9878
500005	01/01/91	12/31/91	1.2646	0.9844
500007	01/01/91	12/31/91	1.7013	0.9979
500009	01/01/91	12/31/91	1.3185	0.9801
500011	01/01/91	12/31/91	1.3636	0.9908
500012	01/01/91	12/31/91	1.2267	0.9869
500014	01/01/91	12/31/91	1.4868	0.9974
500015	01/01/91	12/31/91	1.6738	0.9983
500016	01/01/91	12/31/91	1.2899	0.9881
500019	01/01/91	12/31/91	1.3464	0.9918
500024	01/01/91	12/31/91	1.2249	0.9717
500025	01/01/91	12/31/91	1.3638	0.9893
500026	01/01/91	12/31/91	1.9064	0.9986
500027	01/01/91	12/31/91	1.2769	0.9853
500028	01/01/91	12/31/91	1.5768	0.9985
500029	01/01/91	12/31/91	0.9556	0.9759
500031	01/01/91	12/31/91	0.9233	0.9317
500033	01/01/91	12/31/91	1.2594	0.9678
500035	01/01/91	12/31/91	1.1896	0.9410
500036	01/01/91	12/31/91	1.3940	0.9937
	11/01/90	10/31/91	1.2793	0.9932

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
500037	01/01/91	12/31/91	1.1866	0.9863
500042	01/01/91	12/31/91	1.3228	0.9787
500043	01/01/91	12/31/91	1.2249	0.9400
500044	01/01/91	12/31/91	1.8839	0.9997
500045	01/01/91	12/31/91	1.2083	0.9879
500048	08/01/90	07/31/91	0.9433	0.9687
500049	01/01/91	12/31/91	1.2372	0.9888
500050	10/01/90	09/30/91	1.2736	0.9903
500051	10/01/90	09/30/91	1.6321	0.9983
500052	01/01/91	12/31/91	1.2104	0.9953
500053	01/01/91	12/31/91	1.2501	0.9828
500054	01/01/91	12/31/91	1.8535	0.9987
500055	08/01/90	07/31/91	0.9833	0.9633
500057	10/01/90	09/30/91	1.2811	0.9876
500058	01/01/91	12/31/91	1.3570	0.9821
500059	01/01/91	12/31/91	1.1252	0.9543
500060	01/01/91	12/31/91	1.2055	0.9735
500061	01/01/91	12/31/91	1.1906	0.9042
500062	01/01/91	12/31/91	0.9371	0.9237
500065	01/01/91	12/31/91	1.3252	0.9609
500068	01/01/91	12/31/91	1.1557	0.9956
500069	01/01/91	12/31/91	1.0029	0.9055
500071	01/01/91	12/31/91	1.3758	0.9506
500072	01/01/91	12/31/91	1.1995	0.9816
500073	01/01/91	12/31/91	0.9586	0.9693
500074	01/01/91	12/31/91	1.0982	0.9839
500077	08/01/90	07/31/91	1.2387	0.9871
500078	11/01/90	10/31/91	1.2867	0.9929
500079	10/01/90	09/30/91	1.2507	0.9820
500080	01/01/91	12/31/91	0.8805	0.9175
500084	01/01/91	12/31/91	1.0142	0.9832
500085	01/01/91	12/31/91	1.0608	0.9527
500088	01/01/91	12/31/91	1.3045	0.9908
500089	01/01/91	12/31/91	0.9888	0.9783
500090	01/01/91	12/31/91	0.8569	0.9231
500092	01/01/91	12/31/91	1.1096	0.9779
500094	01/01/91	12/31/91	0.8671	0.8975
500096	01/01/91	12/31/91	1.0038	0.9390
500097	01/01/91	12/31/91	1.1901	0.9742
500098	01/01/91	12/31/91	0.9062	0.9932
500101	01/01/91	12/31/91	0.8961	0.9377
500102	01/01/91	12/31/91	0.9386	0.9654
500106	01/01/91	12/31/91	0.9803	0.9633
500107	01/01/91	12/31/91	1.1532	0.9787
500110	01/01/91	12/31/91	1.2111	0.9813
500118	01/01/91	12/31/91	1.2002	0.9498
500119	01/01/91	12/31/91	1.2372	0.9838
500122	01/01/91	12/31/91	1.2396	0.9672
500123	01/01/91	12/31/91	0.9900	0.9627
500124	01/01/91	12/31/91	1.3030	0.9846
500125	01/01/91	12/31/91	0.9645	0.9397
500129	01/01/91	12/31/91	1.6686	0.9974
500132	01/01/91	12/31/91	0.8387	0.9585
500134	01/01/91	12/31/91	0.7658	0.9936
500140	10/01/90	09/30/91	0.9810	1.0000
510001	01/01/91	12/31/91	1.6762	0.9936
510002	09/01/90	08/31/91	1.2913	0.9771
510004	11/01/90	10/31/91	0.9587	0.9273
510005	01/01/91	12/31/91	0.9445	0.9613
510006	10/01/90	09/30/91	1.2050	0.9868
510007	10/01/90	09/30/91	1.3756	0.9997
510008	01/01/91	12/31/91	1.1462	0.9927
510009	01/01/91	12/31/91	1.0408	0.9810
510012	10/01/90	09/30/91	1.0412	0.9833
510013	10/01/90	09/30/91	1.1464	0.9939
510016	01/01/91	12/31/91	0.9640	0.9660
510018	10/01/90	09/30/91	1.1305	0.9814
510022	01/01/91	12/31/91	1.6335	0.9985
510028	01/01/91	12/31/91	1.0591	0.9894
510029	10/01/90	09/30/91	1.2375	0.9890
510030	10/01/90	09/30/91	1.1187	0.9924
510031	01/01/91	12/31/91	1.2671	0.9930
510033	01/01/91	12/31/91	1.2335	0.9932
510038	10/01/90	09/30/91	1.0024	0.9676
510039	01/01/91	12/31/91	1.2758	0.9928
510040	01/01/91	12/31/91	0.9602	0.9911
510047	01/01/91	12/31/91	1.1351	0.9831

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL—SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
510048	01/01/91	12/31/91	1.1573	0.9860
510050	10/01/90	09/30/91	1.2335	0.9931
510053	10/01/90	09/30/91	1.0016	0.9626
510055	10/01/90	09/30/91	1.1704	0.9937
510059	01/01/91	12/31/91	1.3021	0.9908
510060	09/01/90	08/31/91	1.1601	0.9844
510063	01/01/91	12/31/91	1.0489	0.9627
510065	01/01/91	12/31/91	0.9841	0.9622
510066	01/01/91	12/31/91	1.1224	0.9905
510067	09/01/90	08/31/91	1.2654	0.9912
510068	10/01/90	09/30/91	1.1022	0.9784
510076	01/01/91	12/31/91	1.0242	0.9863
510077	10/01/90	09/30/91	1.1352	0.9899
510081	10/01/90	09/30/91	1.0050	0.9749
510082	01/01/91	12/31/91	1.0014	0.9690
510084	01/01/91	12/31/91	0.9518	0.9603
510085	10/01/90	09/30/91	1.1973	0.9861
520002	10/01/90	09/30/91	1.2780	0.9778
520003	01/01/91	12/31/91	1.1432	0.9629
520008	10/01/90	08/30/91	1.2056	0.9883
520010	01/01/91	12/31/91	1.0845	0.9551
520012	10/01/90	09/30/91	0.9411	0.9521
520014	10/01/90	09/30/91	1.1710	0.9849
520018	10/01/90	09/30/91	0.9627	0.9612
520019	10/01/90	09/30/91	1.2388	0.9826
520021	10/01/90	09/30/91	1.1852	0.9899
520024	10/01/90	09/30/91	0.9845	0.9657
520026	01/01/91	12/31/91	1.0865	0.9827
520029	10/01/90	09/30/91	0.9270	0.9722
520031	10/01/90	09/30/91	1.1637	0.9811
520032	10/01/90	09/30/91	1.1472	0.9642
520033	09/01/90	08/31/91	1.2481	0.9628
520034	10/01/90	09/30/91	1.1804	0.9768
520035	01/01/91	12/31/91	1.2333	0.9877
520037	10/01/90	09/30/91	1.6024	0.9989
520038	01/01/91	12/31/91	1.2627	0.9821
520039	01/01/91	12/31/91	1.0191	0.9460
520042	10/01/90	09/30/91	1.0163	0.9527
520045	01/01/91	12/31/91	1.6931	0.9986
520048	10/01/90	09/30/91	1.3200	0.9888
520049	10/01/90	09/30/91	1.8080	0.9955
520053	01/01/91	12/31/91	1.0808	0.9380
520054	01/01/91	12/31/91	1.1890	0.9766
520056	10/01/90	09/30/91	1.3019	0.9903
520057	01/01/91	12/31/91	1.1617	0.9809
520058	10/01/90	09/30/91	1.1012	0.9714
520059	10/01/90	09/30/91	1.2678	0.9718
520060	10/01/90	09/30/91	1.2476	0.9593
520062	10/01/90	09/30/91	1.1787	0.9764
520064	12/30/90	12/28/91	1.5396	0.9890
520069	01/01/91	12/31/91	1.1928	0.9904
520070	01/01/91	12/31/91	1.3637	0.9855
520071	10/01/90	09/30/91	1.1819	0.9715
520077	10/01/90	09/30/91	1.0274	0.9813
520078	01/01/91	12/31/91	1.3239	0.9922
520082	08/01/90	07/31/91	1.2997	0.9803
520083	01/01/91	12/31/91	1.5158	0.9984
520084	10/01/90	09/30/91	1.0874	0.9651
520089	01/01/91	12/31/91	1.4474	0.9959
520090	10/01/90	09/30/91	1.1410	0.9620
520095	01/01/91	12/31/91	1.3340	0.9685
520100	01/01/91	12/31/91	1.2255	0.9815
520101	10/01/90	09/30/91	1.1709	0.9682
520102	01/01/91	12/31/91	1.2104	0.9721
520103	10/01/90	09/30/91	1.3486	0.9802
520107	01/01/91	12/31/91	1.2459	0.9661
520109	10/01/90	09/30/91	1.0769	0.9788
520110	01/01/91	12/31/91	0.9853	0.9917
520113	10/01/90	09/30/91	1.2143	0.9803
520115	10/01/90	09/30/91	1.2829	0.9658
520116	10/01/90	09/30/91	1.2023	0.9736
520117	09/01/90	08/31/91	1.0600	0.9693
520118	01/01/91	12/31/91	0.9669	0.9541
520123	10/01/90	09/30/91	1.0428	0.9540
520130	10/01/90	09/30/91	1.0552	0.9091
520131	01/01/91	12/31/91	1.0519	0.9348
520135	01/01/91	12/31/91	1.0352	0.9618

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
520138	12/30/90	12/28/91	1.8574	0.9979
520139	09/03/90	09/01/91	1.1996	0.9834
520140	01/01/91	12/31/91	1.4267	0.9974
520144	10/01/90	09/30/91	1.0104	0.9588
520145	01/01/91	12/31/91	1.0190	0.9970
520146	01/01/91	12/31/91	1.1808	0.9655
520148	01/01/91	12/31/91	1.1001	0.9651
520149	01/01/91	12/31/91	1.0452	0.9498
520152	10/01/90	09/30/91	1.1381	0.9665
520153	10/01/90	09/30/91	1.0132	0.9362
520154	10/01/90	09/30/91	1.1116	0.9678
520156	01/01/91	12/31/91	1.0869	0.9421
520157	01/01/91	12/31/91	1.0253	0.9825
520160	01/01/91	12/31/91	1.7842	0.9954
520171	01/01/91	12/31/91	0.9747	0.9766
520173	10/01/90	09/30/91	1.0623	0.9807
520174	01/01/91	12/31/91	1.4356	0.9874
520177	01/01/91	12/31/91	1.5539	0.9929
530008	01/01/91	12/31/91	1.1720	0.9834
530010	01/01/91	12/31/91	1.2714	0.9902
530023	01/01/91	12/31/91	0.8741	0.9478
530024	01/01/91	12/31/91	0.9679	0.9300
530032	01/01/91	12/31/91	1.2207	0.9549

Appendix A—Regulatory Impact Analysis

I. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 criteria for a "major rule;" that is, a rule that would be likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- A significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the

exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area or a New England County Metropolitan Area.

Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent New England Metropolitan County. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes being implemented in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291 and the RFA.

II. Changes in the Final Rule

There are no major policy changes in this final rule compared to those in the proposed rule. Consequently, in general, the differences in this final rule impact analysis compared to that in the proposed rule are the result of using later or more complete hospital data. For example, a more complete FY 1991 MEDPAR file is now available compared to the one available at the

time of the proposed rule. In addition, more recent hospital-specific data, including cost reports, are used in this analysis.

Since publication of the June 4, 1992 proposed rule, the latest hospital market basket forecast provides an increase of 4.1 percent in the operating costs of hospitals paid under the prospective payment system, compared to the 4.3 percent increase projected in the proposed rule. This results in a 2.55 percent increase in the standardized payment amounts for hospitals paid the urban rate rather than the 2.75 percent increase projected at the time of the proposed rule. The rural standardized amounts will increase by 3.55 percent rather than 3.75 percent. The hospital-specific rates for sole community hospitals and Medicare-dependent, small rural hospitals will increase by 4.1 percent. For hospitals excluded from the prospective payment system, the increase in the market basket is now projected to be 4.2 percent, down from a projected 4.5 percent at the time of the proposed rule.

With regard to the capital prospective payment system, we have revised our estimate of the rate of increase in capital costs per case and our budget neutrality target. The FY 1993 Federal rate and the hospital-specific rate will increase 0.4 percent and 0.62 percent, respectively, from their FY 1992 levels. However, our estimate of FY 1993 capital costs per case, which is used to establish the budget neutrality target, is lower than in the proposed rule. We

now estimate that FY 1993 payments per case will increase 6.2 percent over FY 1992 levels. The impacts of these revised increases are illustrated in the analyses below.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis is limited to presenting the projected effects of the final policy and rate changes on current and projected payment rates. In this analysis, we examine the effects on hospital operating and capital payments of both statutory and regulatory policy. The analysis projects estimated payments under each major statutory or policy change while holding all other payment variables constant and compares these with current estimated payments to calculate the percentage differences. We cannot, however, predict behavioral responses to our policy changes, and we are not generally accounting for changes in such exogenous variables as admissions, lengths of stay, or case mix. We would expect hospitals to adapt to many of these changes, however. To the extent they are able to do so, the actual impacts of these changes will vary from the estimates discussed below.

IV. Hospitals Included In and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. Only 57 short-term, acute care hospitals remain excluded from the prospective payment systems under section 1814(b)(3) of the Act (in Maryland) or a demonstration project (in the Finger Lakes region of New York State). Thus, as of August 1992, just under 5,400 hospitals were receiving prospectively based payments for their Medicare inpatient services. This represents about 83 percent of all Medicare-participating hospitals.

Among the 5,386 prospective payment hospitals included in our analysis, there are over 850 hospitals that are paid on special bases under the prospective payment system for operating costs, as required by statute, as sole community hospitals or rural referral centers. As discussed above in section IV.B.3 of the preamble to this final rule, we are implementing triennial reviews of hospitals' eligibility for rural referral center status during FY 1993, and we expect some hospitals currently designated as rural referral centers will lose their status. We have included all current rural referral centers in the

tables in this impact analysis, however, without projecting which hospitals may no longer meet the criteria. In addition, there are approximately 1,600 hospitals that receive additional payments on the basis of qualifying as disproportionate share hospitals. Of these hospitals, 46 also receive special payments as rural referral centers, and 101 as sole community hospitals. Our analysis identified 1,041 hospitals that are receiving additional payments for the indirect cost of medical education, reduced from 1,207 in the proposed rule. This reduction is the result of our identification of a number of hospitals, most of which were previously reported as small teaching programs, that are in fact no longer teaching hospitals. There are approximately 560 urban hospitals that qualify for additional payments under both the indirect medical education and disproportionate share payment provisions under the prospective payment system for operating costs.

Section 1886(d)(5)(G)(i) of the Act directs the Secretary to pay Medicare-dependent, small rural hospitals on the basis of the greater of a hospital-specific rate based on their FY 1982 or FY 1987 operating costs per discharge, whichever is higher, or the applicable standardized payment amount. This provision was effective with cost reporting periods beginning after April 1, 1990, and expires with cost reporting periods ending on or before March 31, 1993. According to the latest hospital-specific data, some of these hospitals have already begun to lose their special status (cost reporting periods beginning on May 1, 1992, for example). For purposes of the operating impact analysis, we have shown all hospitals that qualified for this special provision as of the beginning of FY 1992 in the tables. There are 501 such hospitals in our analysis. Since this special provision is not applicable for capital payments, we have grouped these hospitals according to the most recent data, which results in a decline to 443 in the number of Medicare-dependent, small rural hospitals shown in the capital impact tables.

Under the capital prospective payment system, approximately 2,250 urban hospitals with more than 100 beds receive an additional payment for serving low-income patients. (A capital disproportionate share adjustment is made to all urban hospitals with more than 100 beds that serve low-income patients.) Additional capital payments are also made to the 1,041 hospitals that we have identified as teaching hospitals.

In addition, there are special payment protections for sole community hospitals and for urban hospitals with 100 or more beds that either have a disproportionate share percentage of at least 20.2 percent or derive at least 30 percent of their total inpatient revenues from State or local government sources for the care of indigent patients. We have identified 561 sole community hospitals and about 760 urban hospitals that qualify for these special provisions.

As of August 1992, about 1,050 Medicare hospitals are excluded by statute from the prospective payment system and continue to be paid on the basis of their reasonable costs, subject to limits on the rate of increase in their costs. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another 1,893 psychiatric and rehabilitation units in hospitals subject to the prospective payment system are excluded from the prospective payment system as of the same date. These units, too, are paid on the basis of reasonable cost subject to limits on the rate of increase in their costs. In addition, there are nine hospitals extensively involved either in the treatment of cancer or cancer research that are excluded from the prospective payment system.

V. Impact on Excluded Hospitals and Units

As noted in the previous section of this impact analysis, approximately 1,050 excluded hospitals and 1,893 excluded units in hospitals included in the prospective payment systems are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of \$ 413.40. For hospital cost reporting periods beginning on or after October 1, 1992, excluded hospitals and units will be paid the full increase in their reasonable costs up to the percentage increase in the hospital market basket. We are projecting an increase in the excluded hospital market basket of 4.2 percent.

The impact of this update in the rate-of-increase limit on excluded hospitals and units depends on the rate of cost increases experienced by each hospital and excluded unit since its base period. For excluded hospitals and units with per case increases in inpatient operating costs below the cumulative update in their rate-of-increase limit, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with cost increases per case above the cumulative update in their rate-of-increase limit, the major

effect will be the amount of excess costs that the hospitals will have to absorb.

In this context, we note that for cost reporting periods beginning in FY 1992, section 1886(b)(1)(B) of the Act allows an excluded hospital or unit whose costs exceed the rate-of-increase limit to receive the lower of its target amount plus 50 percent of reasonable costs in excess of the target amount or 110 percent of the target amount. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units can obtain substantial relief from the rate-of-increase limit for significant and justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases to the growth rate in the hospital market basket, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are implementing policy changes and payment rate updates for the prospective payment systems for operating costs and for capital-related costs. We have prepared a separate analysis of the changes to each system.

The data used in developing the quantitative analysis of changes in operating payments that are presented below are taken from FY 1991 MEDPAR data and the most current hospital-specific data. For purposes of determining which method of payment to apply for sole community hospitals (the Federal payment rate or the applicable hospital-specific payment rate as prescribed by section 1886(d)(5)(D)(i) of the Act), we assume that all sole community hospitals have a cost reporting period that coincides with the Federal fiscal year.

Our analysis has several limitations. First, as noted above, it does not take into account behavioral changes that hospitals may adopt in response to the policy changes. Second, we are unable to precisely quantify every effect of the changes contained in this rule. Given the data we have available, however, we have attempted to estimate payments under each scenario as precisely as possible. Third, we could not categorize every hospital in accordance with the groupings we examined because in some cases the hospital-specific data necessary to do so were missing. For example, parts of the data needed to

determine Medicare's utilization percentage were missing for 245 hospitals.

To illustrate the effects of hospital geographic reclassifications for FY 1993, hospitals are grouped in Table I based on both their actual geographic location and their actual payment classification after any reclassifications under sections 1886(d)(8) or (10) of the Act. For example, Table I shows that the numbers of prospective payment hospitals actually located in large urban, other urban, and rural areas are 1,474, 1,422, and 2,490, respectively. The corresponding numbers of hospitals in these three groups after geographic reclassification shows the numbers of large urban, other urban, and rural hospitals to be 1,628, 1,487, and 2,271, respectively. The effects of geographic reclassification are further evident in column 2 and in the row groupings of reclassified and nonreclassified hospitals.

To simulate the impact of the expiration of the provisions of section 1886(d)(5)(G) of the Act on payments to Medicare-dependent, small rural hospitals (MDHs), we computed hospital-specific payments from October 1, 1992 through the end of each MDH's cost reporting period that ends on or before March 31, 1993. That is, we simulated payments for this period based on the higher of the hospital-specific payment or the FY 1993 standardized amount payments for operating costs. We then computed payments for the remainder of the Federal fiscal year based on the FY 1993 standardized amount payments for operating costs. For example, if the hospital's cost reporting period ends December 31 and the hospital-specific payments are higher than the standardized amount payments, we computed hospital-specific payments for 3 months and payments under the standardized amounts for 9 months. Hospitals with cost reporting periods ending after March 31 and on or before September 30 were paid on the basis of the Federal payment rates for the entire period. Since some MDHs lost their special protection during FY 1992 (for example, MDHs with cost reporting periods beginning July 1), a similar reduction was made in estimated FY 1992 payments. The annual impact on MDHs of the expiration of this special provision is illustrated below. We simulated a full 12 months of FY 1993 payments to MDHs under the special provision compared with 12 months of payment without the provision.

Average payment/ case 12 months payment as an MDH	Average payment/ case 12 months payment without the MDH payment protection	Percent change
\$3,446	\$3,114	-9.6

The analysis in Table I examines the following major changes set forth in this final rule—

- The effects of the annual reclassification of DRGs and the recalibration of the DRG weights required by section 1886(d)(4)(C) of the Act (column 1).
- The effects of hospital reclassifications by the MCCR (column 2).
- The effects of the additional outlier payments that we estimate will be made during FY 1993 compared to our estimate of FY 1992 outlier payments (column 3A).
- The effect of the outlier payment changes (using a marginal cost factor of .55 and the arithmetic mean to calculate day outlier payments) and increase in outlier payment levels (column 3B).
- The net effect of the outlier changes shown in columns 3A and 3B (column 3C).
- The combined effect of all changes being presented in this final rule (column 4).

In order to present the effects of the separate policy changes displayed in columns 1, 2, 3A, 3B, and 3C of Table I, we added each change incrementally, so that the percentages in the columns represent the differences in payments relative to the previous column. The baseline for comparison is an FY 1993 system absent any of the changes described above. It does reflect the statutory MDH phase-out during FY 1993. For example, column 1 displays the impacts of the DRG reclassifications and recalibration relative to estimated FY 1993 payments absent these changes. Similarly, column 2 examines the impacts of the standardized amount and wage index changes resulting from geographic reclassifications exclusive of the effects of the DRG reclassifications and recalibration. Columns 3A, 3B, and 3C show the impacts of the outlier changes in a similar manner. The last column in Table I displays the combined changes from the previous columns, as well as corrections to the wage index values, the phase-out of the MDH provision, and the update and budget neutrality factors. This column compares estimated final FY 1993 payments to estimated FY 1992 payments. Thus, the last column is the only one that reflects the effects of all

the quantifiable policy changes on simulated FY 1993 payments.

TABLE I.—IMPACT OF CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM FOR OPERATING COSTS FOR FY 1993

[Percent Change in Payments]

	Number of hospitals ¹	DRG reclassification and recalibration ² (1)	Geographic reclassification ² (2)	Outlier Payment Changes			
				Payment level adjust. ⁴ (3A)	Proposed policy ⁵ (3B)	Sum of (A) & (B) (3C)	All changes ⁶ (4)
By geographic location:							
All hospitals	5,386	0.0	0.0	1.4	0.0	1.4	4.0
Large urban areas (populations over 1 million)	1,474	0.1	-0.1	1.6	-0.1	1.5	4.1
Other urban areas (populations of 1 million or fewer)	1,422	0.0	0.1	1.5	0.1	1.6	4.2
Rural areas	2,490	-0.1	0.1	0.6	0.0	0.6	3.0
Urban hospitals	2,896	0.0	0.0	1.6	0.0	1.6	4.1
0-99 beds	682	-0.1	0.0	0.9	0.2	1.1	3.7
100-199 beds	872	0.1	0.1	1.2	0.2	1.4	4.1
200-299 beds	612	0.1	0.0	1.4	0.1	1.5	4.2
300-499 beds	537	0.0	-0.1	1.7	-0.1	1.6	4.1
500 or more beds	193	0.0	0.0	1.9	-0.3	1.6	4.2
Rural hospitals	2,490	-0.1	0.1	0.6	0.0	0.6	3.0
0-49 beds	1,232	-0.2	0.2	0.1	0.0	0.1	2.0
50-99 beds	761	-0.1	0.2	0.3	0.0	0.3	2.6
100-149 beds	259	0.0	0.0	0.6	0.1	0.7	3.1
150-199 beds	123	0.0	-0.1	0.7	0.0	0.7	3.6
200-499 beds	112	0.0	-0.2	1.1	0.0	1.1	3.6
500 or more beds	3	-0.1	-0.4	0.9	0.1	1.0	3.5
Urban by region:							
New England	172	-0.2	0.3	1.6	-0.3	1.3	4.0
Middle Atlantic	456	0.4	0.0	2.1	-1.2	0.9	3.8
South Atlantic	421	-0.1	0.0	1.7	0.2	1.9	4.4
East North Central	476	0.0	-0.2	1.3	0.3	1.6	4.0
East South Central	168	0.1	-0.1	1.7	0.4	2.1	4.7
West North Central	183	-0.1	-0.2	1.3	0.4	1.7	3.9
West South Central	357	0.1	0.3	1.5	0.5	2.0	5.0
Mountain	113	-0.1	-0.2	1.4	0.5	1.9	4.3
Pacific	501	-0.2	0.0	1.3	0.4	1.7	3.9
Puerto Rico	49	0.2	-0.2	0.8	0.1	0.9	3.5
Rural by region:							
New England	56	-0.1	-0.2	0.8	0.0	0.8	3.9
Middle Atlantic	93	0.0	-0.4	1.1	-0.8	0.3	1.5
South Atlantic	340	0.0	-0.7	1.0	0.0	1.0	3.1
East North Central	344	-0.1	0.5	0.4	0.1	0.5	2.9
East South Central	298	0.0	-0.2	0.6	0.1	0.7	3.4
West North Central	564	-0.2	0.7	0.2	0.1	0.3	2.3
West South Central	396	-0.1	0.5	0.5	0.2	0.7	3.2
Mountain	237	-0.2	0.0	0.3	0.1	0.4	3.5
Pacific	156	-0.1	0.8	0.3	0.1	0.4	4.1
Puerto Rico	6	-0.1	-0.4	0.2	0.1	0.3	3.3
By payment classification:							
All Hospitals	5,386	0.0	0.0	1.4	0.0	1.4	4.0
Large Urban areas (populations over 1 million)	1,628	0.1	0.0	1.6	-0.1	1.5	4.2
Other Urban areas (populations of 1 million or fewer)	1,487	0.0	0.0	1.4	0.1	1.5	4.1
Rural areas	2,271	-0.1	-0.1	0.5	0.0	0.5	2.8
Teaching status:							
Non-teaching	4,345	0.0	0.0	1.2	0.2	1.4	3.9
Resident/bed ratio less than 0.25	811	0.0	-0.1	1.5	-0.1	1.4	3.9
Resident/bed ratio 0.25 or greater	230	0.1	0.1	2.0	-0.5	1.5	4.2
Disproportionate share hospitals (DSH):							
Non-DSH	3,734	-0.1	0.0	1.3	0.1	1.4	3.9
Urban DSH:							
100 beds or more	1,161	0.1	0.0	1.6	-0.2	1.4	4.1
Fewer than 100 beds	99	-0.1	0.0	0.6	0.2	0.8	3.3
Rural DSH:							
Sole Community (SCH)	101	0.0	-0.5	0.3	0.0	0.3	3.3
Referral Centers (RRC)	46	0.0	0.4	1.0	-0.1	0.9	3.9
Other rural DSH hospitals:							
100 beds or more	66	0.0	-2.4	0.8	-0.1	0.7	1.7
Fewer than 100 beds	179	-0.2	-0.4	0.3	0.0	0.3	2.8
Urban teaching and DSH:							
Both teaching and DSH	561	0.1	0.0	1.8	-0.4	1.4	4.1
Teaching and no DSH	429	-0.1	-0.1	1.8	0.1	1.7	4.0
No teaching and DSH	699	0.1	0.0	1.3	0.1	1.4	4.1
No teaching and no DSH	1,426	0.0	0.1	1.4	0.2	1.6	4.3
Rural hospital types:							
Non special status	983	-0.1	-0.9	0.5	0.0	0.5	3.1
RRC	180	0.0	0.4	0.9	0.1	1.0	3.9
SCH	561	-0.1	0.0	0.1	0.0	0.1	3.8
Medicare-dependent (MDH)	501	-0.2	0.3	0.2	0.0	0.2	-4.0

TABLE I.—IMPACT OF CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM FOR OPERATING COSTS FOR FY 1993 —Continued

[Percent Change in Payments]

	Number of hospitals ¹	DRG reclassification and recalibration ² (1)	Geographic reclassification ³ (2)	Outlier Payment Changes			
				Payment level adjust. ⁴ (3A)	Proposed policy ⁵ (3B)	Sum of (A) & (B) (3C)	All changes ⁶ (4)
SCH and RRC	46	0.1	0.2	0.5	-0.3	0.2	3.7
SCH or MDH	1,108	-0.1	0.1	0.2	-0.1	0.1	1.6
Type of ownership:							
Voluntary	3,212	0.0	-0.1	1.5	-0.1	1.4	3.9
Proprietary	729	0.0	0.0	1.5	0.4	1.9	4.6
Government	1,445	0.0	0.2	1.2	0.0	1.2	3.8
Medicare utilization							
Percent of days:							
0-25%	293	0.2	0.0	1.4	-0.1	1.3	4.1
25-50%	1,782	0.0	0.0	1.6	0.0	1.6	4.1
50-65%	2,201	0.0	0.0	1.3	0.0	1.3	4.0
Over 65%	865	0.1	-0.1	1.1	0.0	1.1	2.9
N/A	245	0.4	0.6	1.6	-0.5	1.1	4.7

Hospitals Reclassified by the Medicare Geographic Classification Review Board

Reclassification Status during FY 1992 and FY 1993:							
Reclass. FY92 and FY93	849	0.0	-0.7	1.0	0.0	1.0	3.1
Reclass. FY93 only	344	0.2	4.4	1.4	-0.3	1.1	8.2
Reclass. FY92 only	80	0.0	-3.1	1.0	0.2	1.2	0.8
FY93 reclassifications—All hospitals:							
Reclassified	1,193	0.0	1.0	1.2	-1.0	1.1	4.7
Nonreclassified	4,143	0.0	-0.3	1.5	0.0	1.5	3.8
Urban hospitals:							
Reclassified	370	0.1	1.4	1.5	-0.2	1.3	5.5
Nonreclassified	2,526	0.0	-0.3	1.6	0.0	1.6	3.9
Rural Hospitals:							
Reclassified	823	-0.1	0.3	0.7	0.0	0.7	3.6
Nonreclassified	1,617	-0.1	-0.4	0.4	0.0	0.4	2.1
Other Reclassified Hospitals: (Section 1886(d)(8)(B))	50	0.0	0.2	0.9	0.1	1.0	3.8

¹ Because data necessary to classify some hospitals by category were missing, these hospitals were not categorized, or are shown as N/A. Therefore, the total number of hospitals in each category may not equal the national total. Hospital-specific data and number of discharges data are from FY 1991, and hospital cost report data are from cost reporting periods beginning in FY 1990.

² Recalibration of the DRG weights and classification changes are based on FY 1991 MEDPAR data and are performed annually in accordance with section 1886(d)(4)(C) of the Act.

³ Under section 1886(d)(10) of the Act, a hospital may apply to the Medicare Geographic Classification Review Board for the purpose of obtaining a higher wage index, standardized payment amount, or both. Under section 1886(d)(8)(D) of the Act, changes in the geographic designation of hospitals must be budget neutral and payments to rural hospitals after reclassification cannot be lower than they would be absent reclassification. This column reflects the impact of changes in reclassifications between FY 1992 and FY 1993.

⁴ This column displays the effects of increasing outlier payments between FY 1992 and FY 1993. The thresholds implemented for FY 1992 were intended to result in 5.1 percent of payments for outlier cases. FY 1992 outlier payments are now estimated to equal 3.84 percent of total prospective payments. FY 1993 outlier payments are estimated at 5.1 percent.

⁵ This column displays the impact of the change for computing day outlier cases as follows: using the arithmetic mean length of stay in place of the geometric mean length of stay for computing the per diem payment amount and using a marginal cost factor of .55 instead of .60.

⁶ This column shows the combined effects of all the previous columns as well as the effects of updating the standardized amounts in accordance with section 1886(b)(3)(B)(i)(VII) of the Act. It also reflects the phase-out of the Medicare-dependent, small rural hospital provision. In addition, this column captures any interactive effects that we are not able to quantify.

B. The Impact of the Changes to the DRG Weights (Column 1)

In column 1 of Table I, we present the combined effects of the revised DRG classification system and the subsequent recalibration of the DRG weights incorporating these redefined DRGs. Section 1886(d)(4)(C)(i) of the Act requires us to make appropriate classification changes and recalibrate the DRG weights each year in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The impact of reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

The redistributive impact of the classification and recalibration changes across hospital groupings is small. Column 1 shows that, for most hospital groups, the impact of this change would be between plus or minus 0.2 percent difference relative to payments without these changes. The reductions occur primarily among small urban and rural hospitals. The impact on rural hospitals overall is 0.1 percent lower payments. Rural hospitals with fewer than 50 beds are projected to lose an average of 0.2 percent in payments per case, and rural hospitals with between 50 and 99 beds are projected to lose 0.1 percent of their payments. Also, urban hospitals with fewer than 100 beds can expect an average 0.1 percent reduction in payments per case. However, urban

hospitals with between 100 and 299 beds can expect an average increase in payments of 0.1 percent. An exception to the generally minimal impact are urban hospitals in the Middle Atlantic region. Their payments increase by 0.4 percent due to the DRG changes, up from 0.3 percent in the proposed rule.

C. The Impact of MGCRB Reclassifications on Hospitals (Column 2)

1. Impact of Current Policies

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review Board (MGCRB). The first hospital reclassifications based on decisions of the MGCRB were effective October 1, 1991. The MGCRB

considers hospitals' applications for geographic reclassification for purposes of receiving a different wage index value or a higher standardized amount or both under the prospective payment system. The MGCRB may reclassify a hospital to an adjacent urban area or to another rural area with which it has a close proximity for the purposes of using the other area's standardized amount, wage index value, or both. (A rural referral center or a sole community hospital may be redesignated to an area that is not an adjacent county.)

Both the FY 1993 standardized payment amounts and wage index values incorporate all the MGCRB's reclassification decisions that will be effective for FY 1993. The MGCRB approved 1,243 hospital reclassifications for FY 1993. This number includes 50 hospitals that have also been reclassified under provisions of section 1886(d)(8)(B) of the Act, which deems certain rural counties adjacent to one or

more urban areas as belonging to an urban area.

The wage index values and the standardized payment amounts also reflect any decisions that result from the Administrator's review of MGCRB decisions for FY 1993 as of August 1992 and any reclassification withdrawal requests that were received by the MGCRB. These Administrator's decisions and withdrawals may affect the wage index value for specific geographic areas relative to those used in the impact analysis in the June 4, 1992 proposed rule. They may also determine whether a redesignated hospital receives the wage index of the area to which it is redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals.

Approximately 69 percent of all hospitals reclassified for FY 1993 are located in rural areas (823 hospitals). This represents 33 percent of all rural

hospitals in our data base. Of the total number of rural hospitals that were reclassified, 79 percent (652 hospitals) were reclassified for purposes of their wage index. Just under 10 percent of rural reclassified hospitals were reclassified for purposes of their standardized amounts and 11 percent were granted reclassification for purposes of both their wage index and their standardized payment amount.

Among the 245 hospitals located in other urban areas that were reclassified for FY 1993, almost 57 percent (139 hospitals) were reclassified for purposes of increasing their wage index value. Another 36 percent (89 hospitals) were reclassified for purposes of both their wage index value and standardized amount. The following table shows the number (and percentage) of reclassified hospitals by their actual geographic location.

DISTRIBUTION OF RECLASSIFIED HOSPITALS

Geographic location	Total number of hospitals reclassified	Reclassified for both wage index value and standardized amount		Reclassified for standardized amount		Reclassified for wage index	
		Number	Percent	Number	Percent	Number	Percent
Large Urban.....	125	36	28	0	0	89	71
Other Urban.....	245	89	36	17	7	139	57
Rural.....	823	91	11	80	10	652	55
Total.....	1193	216	18	97	8	880	74

Overall, 74 percent of the reclassified hospitals were reclassified for purposes of their wage index value, 8 percent were reclassified for purposes of their standardized amounts, and 18 percent were reclassified for purposes of both their wage index value and standardized payment amount.

In the proposed rule, only 6 hospitals in large urban areas were reclassified for both the standardized amount and the wage index, and 125 hospitals in large urban areas were reclassified for purposes of the wage index only. As shown above, a sizable shift occurred among these hospitals in the interim, so that now 36 are reclassified for both the standardized amount and the wage index, and only 89 are reclassified for the wage index only. This shift resulted from a group application from hospitals in a large urban area that was originally granted reclassification by the MGCRB for the wage index only, but upon review was subsequently granted reclassification for the standardized amount as well. (If a group of hospitals is reclassified, the group is reclassified for both its standardized amount and its

wage index. Although these hospitals are reported reclassified for both, the payment effect is only on the wage index value.)

Table I shows the impact of changes in reclassification status between FY 1992 and FY 1993. The percentage change shown in Column 2 compares payments incorporating the DRG changes and FY 1992 reclassifications with payments based on the FY 1993 MGCRB decisions. For example, for hospitals that were reclassified in FY 1992, only the differences between their FY 1992 and FY 1993 payments attributable to the MGCRB decisions for FY 1993 are shown. For hospitals reclassified in both FY 1992 and FY 1993, the effect of the increased number of MGCRB reclassifications is to reduce their payments by 0.7 percent. The increased number of reclassifications results in a larger budget neutrality reduction applicable to the urban standardized amount and a decrease in the wage index values assigned to reclassified hospitals. Hospitals that were reclassified for the first time in FY 1993 experience a 4.4 percent increase in

payments. Hospitals that were reclassified in FY 1992 but not in FY 1993 will experience a 3.1 percent reduction in payments as a result. This impact is also shown among nonreclassified rural hospitals, where payments are 0.4 percent lower. Fifty-nine rural hospitals that lost their reclassification from FY 1992 to FY 1993 are in this group, and their average decrease in payments per case is 5.8 percent. Overall, geographic reclassification is expected to increase payments per case to rural and other urban hospitals by an average of 0.1 percent, matched by a reduction of 0.1 percent in payments to large urban hospitals. Payments to rural hospitals with fewer than 100 beds are projected to increase by 0.2 percent, while payments to rural hospitals with between 200 and 499 beds will decrease 0.2 percent, and those to hospitals with 500 or more beds are expected to decrease 0.4 percent. Among urban hospitals, we expect hospitals with between 300 and 499 beds to receive an average decrease of 0.1 percent in

payments compared with FY 1992 payments.

Among the hospitals receiving special payments, rural referral centers are expected to benefit the most, receiving an average increase of 0.4 percent in their payments. This net increase, however, is primarily the impact of rural referral centers reclassified during FY 1993 that were not reclassified during FY 1992. The impact of reclassification on this group of hospitals is a 9.2 percent increase. Other rural referral centers experience a negative impact from reclassification, especially those which lost their reclassification from FY 1992 to FY 1993, which experience a 2.7 percent decrease in payments. Nonreclassified rural referral centers' payments are reduced on average 0.1 percent due to the budget neutrality adjustment to the urban standardized amounts. Rural disproportionate share hospitals with 100 or more beds may expect an average decrease in payments of 2.4 percent compared with current levels. This reduction is attributable primarily to a few hospitals in this category that were reclassified to an

urban area in FY 1992 and received disproportionate share payments at the urban rate. Since these hospitals were not reclassified to urban areas for FY 1993, their payments fall dramatically.

The geographic analysis by census division shows that generally hospitals in urban areas are more likely than rural hospitals to receive a decrease in payments and hospitals located in rural areas are, on average, expected to receive an increase. However, there are notable exceptions in both groups. While urban hospitals in several census divisions are projected to receive decreased payments of 0.2 percent, hospitals in the New England and the West South Central census divisions are expected to receive an average increase of 0.3 percent. Also, rural hospitals in the Pacific, West North Central and the West South Central census divisions can expect an increase of 0.8, 0.7, and 0.5 percent, respectively. However, our analysis shows that rural hospitals in the South Atlantic census division can expect average payment reductions of 0.7 percent, the largest decrease of any census division, urban or rural. These

changes result from concentrations of hospitals within these census divisions that are dramatically affected by the FY 1993 geographic reclassifications. For example, in the Pacific division, 12 hospitals reclassified for the first time during FY 1993 have an 11.0 percent average increase in their payments per case due to reclassification. Conversely, in the South Atlantic census division, 9 hospitals that were reclassified during FY 1992 but are not reclassified for FY 1993 will have payments 8.5 percent less than they would have been if they maintained their geographic reclassification.

We conducted an analysis that shows the effects of reclassification on payments to reclassified and non-reclassified hospitals in FY 1993. This analysis is presented in Table II, below. It compares simulated payment levels after the FY 1993 reclassifications with those based on the actual geographic location of reclassified hospitals. In this respect, the analysis in Table II is comparable to the analysis we presented in the August 30, 1991 final rule (56 FR 43350).

TABLE II.—EFFECTS ON PAYMENTS PER CASE OF FY 1993 GEOGRAPHIC RECLASSIFICATION CURRENT RECLASSIFICATION POLICIES

	Number of hospitals	(a) Payment per case without reclassification ¹	(b) Payment per case after reclassification	(c) Percent change in payment per case due to reclassification only ²
FY 93 reclassifications:				
All reclassified hospitals	1,193	4,961	5,187	4.6
Standardized amount only	97	4,892	5,016	2.5
Wage index only	880	4,859	5,081	4.6
Both	216	5,292	5,554	4.9
All urban reclassified hospitals:	370	5,922	6,079	2.6
Standardized amount only	17	6,709	6,687	-0.3
Wage index only	228	5,997	6,165	2.8
Both	125	5,707	5,862	2.7
All reclassified rural hospitals:	823	3,991	4,287	7.4
Standardized amount only	80	3,658	3,881	6.1
Wage index only	652	4,013	4,274	6.5
Both	91	3,987	4,584	15.0
All nonreclassified hospitals:	4,143	6,003	5,932	-1.2
Urban non-reclassified hospitals	2,526	6,357	6,278	-1.3
Rural non-reclassified hospitals	1,617	3,526	3,531	0.2

¹ This column shows payments without regard to any previous MGCRB reclassification decision. This column reflects the fact that reclassifications are in effect for only 1 fiscal year.

² This column only shows the percentage change in payments resulting from decisions of the MGCRB for FY 1993. It does not reflect other changes such as outliers, DRG recalibration & reclassification or the update.

Table II shows the changes in payments per case for all FY 1993 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, and both).

As evidenced by the increase in payment for reclassified hospitals and the decrease in payments for nonreclassified hospitals, the effects of

the MGCRB reclassification decisions are significant. The net impact of reclassification relative to no reclassification is to increase payments per case to reclassified hospitals by 4.6 percent and to decrease payments per case to nonreclassified hospitals by 1.2 percent. Because reclassified hospitals have only 28 percent as many cases as nonreclassified hospitals, the per case payment reduction to nonreclassified

hospitals is smaller than the per case increase to reclassified hospitals. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount will receive the largest percentage increase in payments per case. They experience an average increase of nearly 15.0 percent above what they would experience without reclassification.

The impact on the 17 hospitals located in urban areas that were reclassified for purposes of their standardized amounts is an average decrease in payments per case of 0.3 percent compared to what they would receive if there were no reclassifications. This outcome reflects the effects of the budget neutrality adjustment for urban hospitals and the reclassification of other hospitals from their labor market area. Thus, for the hospitals remaining in the labor market area after the wage index reclassifications, on average the decrease in the wage index value for the area is greater than the increase in their standardized amount after reclassification to a large urban area. Of course, if they were not reclassified, their payments would have decreased even more.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and through the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Nonreclassified urban hospitals (comprising about 61 percent of nonreclassified hospitals) will experience a 1.3 percent decrease in payments per case compared to the level of payments they would receive if there were no reclassifications. The 0.2 percent increase for nonreclassified rural hospitals is largely attributable to a smaller offset to the rural standardized amount for outliers after reclassification. This occurs because the hospitals reclassified for the urban standardized amounts, which have the largest proportion of outlier cases among rural hospitals, are considered as urban hospitals for the purpose of determining the outlier offset percentages after reclassification. The larger rural standardized amount due to the smaller outlier offset results in a net gain for hospitals with the fewest outlier cases (nonreclassified rural hospitals). In the aggregate, payments to hospitals that are receiving the rural standardized payment amounts (which includes rural hospitals reclassified for the wage index only) are budget neutral.

2. Impact of Guideline Changes

Section 412.230(e) of the regulations specifies the criteria a hospital must meet in order to be reclassified from one labor market to an adjacent one for purposes of the wage index. These criteria are based on average hourly wage differences between the two areas. As discussed in section IV of the preamble to this final rule, we are adding an additional criterion that requires a hospital to demonstrate that

its average hourly wage is at least 108 percent of the average hourly wage in its current labor market area. The revised guideline is effective for applications filed by October 1, 1992, which will be reviewed by the MGCRCB in FY 1993. They do not affect payment until FY 1994.

Based on the FY 1993 reclassifications, we estimate that under the new wage guideline, 75 percent of the hospitals that qualified for reclassification based on their wage index values would no longer qualify. This includes 89 percent of the urban hospitals and 67 percent of the rural hospitals that qualified in FY 1993. The following table shows the effect of the new wage guideline on the number of hospitals that would qualify for reclassification under the three reclassification categories and by urban and rural geographic location.

DISTRIBUTION OF HOSPITALS BY RECLASSIFICATION STATUS

Reclassification status	Actual FY 1993 reclassification	Proposed change
All hospitals.....	5386	5386
All reclassified hospitals.....	1193	553
Standardized amount only.....	97	274
Wage index only.....	880	240
Both.....	216	39
All nonreclassified hospitals.....	4143	4833
Hospitals affected by revised guideline.....		817
Changed from wage index only to no reclassification.....		640
Changed from both to standardized amount only.....		177
All reclassified urban hospitals.....	370	170
Standardized amount only.....	17	133
Wage index only.....	228	28
Both.....	125	9
All nonreclassified urban hospitals.....	2526	2726
Urban hospitals affected by revised guideline.....		316
Changed from wage index only to no reclassification.....		200
Changed from both to standardized amount only.....		116
All reclassified rural hospitals.....	823	383
Standardized amount only.....	80	141
Wage index only.....	652	212
Both.....	91	30
All nonreclassified rural hospitals.....	1617	2057
Rural hospitals affected by revised guideline.....		501

DISTRIBUTION OF HOSPITALS BY RECLASSIFICATION STATUS—Continued

Reclassification status	Actual FY 1993 reclassification	Proposed change
Changed from wage index only to no reclassification.....		440
Changed from both to standardized amount only.....		61

For several reasons, it is difficult to estimate the impact the revised guideline will have on FY 1994 reclassifications (the year in which reclassifications based on the revised guidelines take effect). Our estimates are based on the best data available. However, there are several policy changes that we anticipate will occur that will affect our estimates, but whose outcome cannot be predicted at this point. The following is a partial list of expected changes:

- The revised MSA definitions based on the 1990 Census that are expected to be effective for FY 1994 are likely to have a significant impact on hospital classifications. Until the new MSA definitions are released and hospitals are regrouped based on these definitions, the impact on hospital reclassifications cannot be determined.

- As indicated in section IV.C of the preamble to this final rule, we are in the process of evaluating alternative methods for defining labor market areas and refinements could be implemented as early as FY 1994, the year in which reclassifications based on the revised guidelines would take effect. Any refinements to the labor market area definitions could significantly affect the impact of geographic reclassifications.

- Beginning in FY 1994, the wage data used to develop the wage index will be updated annually. The new wage data, together with revised labor market areas, will affect the impact of FY 1994 wage index reclassifications and the number of hospitals that will qualify for reclassification beginning in FY 1995.

D. Effect of Changes in Outlier Payments (Columns 3A, B, and C)

1. Outlier Policy Changes

Table I, column 3A, displays the impact of increased FY 1993 outlier payments compared with estimated FY 1992 outlier payments. Ordinarily, we account for the difference between the estimated outlier payment percentage in the current year and the outlier payment percentage for the subsequent year in the "All Changes" column of Table I.

However, given the magnitude of the difference between the estimated FY 1992 outlier payments and the 5.1 percent estimated for FY 1993, we are explicitly displaying the increase that will occur in total outlier payments in column 3A rather than in column 4. However, because of its significance, we discuss first the impact of the outlier policy changes shown in column 3B, and then the impact of the outlier payment level.

Under current regulations at § 412.82(c), we compute the per diem DRG payment amount for day outlier cases by dividing the adjusted DRG payment amount by the geometric mean length of stay for the DRG. We then multiply the per diem amount by a marginal cost factor of 60 percent times the number of days beyond the outlier threshold that the patient remains in the hospital. As explained in section V.A.1. of the preamble to this final rule, analysis conducted by the RAND Corporation shows that using the arithmetic mean length of stay in place of the geometric mean length of stay, and using a marginal cost factor of 55 percent instead of 60 percent, results in more appropriate payments for day outlier cases. These changes also produce a more equitable distribution of payments across all outlier cases and better protect hospitals from losses resulting from cost outlier cases.

Since we have made the aggregate effect of the change in outlier policy budget neutral, there is no overall effect on payments under the prospective payment system. Similarly, because there are separate outlier offsets to the urban and rural standardized amounts, there is no payment redistribution between urban and rural hospitals. When examined by census division, however, the effects of these changes are quite pronounced. Except for hospitals in the New England, Puerto Rico and Middle Atlantic divisions, we project increases in payments to urban hospitals of between 0.2 and 0.5 percent. Urban hospitals in the Middle Atlantic and New England census divisions would experience decreases in their payments of 1.2 and 0.3 percent, respectively. This is because hospitals in these regions have a higher percentage of cases meeting the criteria to qualify as day outliers under the current policy. For rural hospitals, we find similar though less dramatic redistributive effects. The impact on rural hospitals in the Middle Atlantic census division is projected to be a reduction of 0.8 percent.

Our analysis indicates that the effect of this change is that payments per case

to large hospitals (over 500 beds) located in urban areas will be about 0.3 percent less. The effect on hospitals located in large urban areas will be 0.1 percent lower payments per case. On the other hand, payments per case to urban hospitals with fewer than 100 beds increase about 0.2 percent.

Among hospitals receiving special payments, payments to hospitals with large teaching programs (resident-to-bed ratios of 0.25 or greater) are reduced 0.6 percent. Estimated payments to disproportionate share hospitals will be 0.3 percent lower. These average payment reductions reflect the reduced payments to hospitals in the Middle Atlantic census division. This is the only census division where payments per case to teaching and disproportionate share hospitals would be decreased.

The principal impact, however, of these changes in day outlier payment policy appears to be one of redistributing payments from hospitals in two of the census divisions to hospitals in the other census divisions, especially among hospitals located in urban areas.

2. FY 1992 Outlier Payments

Section 1886(d)(5)(A)(iv) of the Act requires that the total amount of additional payments made for outlier cases in a fiscal year may not be less than 5 percent nor more than 6 percent of the total prospective payments estimated to be made for discharges in that fiscal year. As described in the August 30, 1991 final rule (56 FR 43246), we established the thresholds for day and high cost outliers based on an estimate that outlier payments would equal 5.1 percent of total prospective payments. In addition, we reduced the standardized amounts by 5.1 percent for the estimated outliers payments. As the analysis in section V.A.4 of the preamble to this final rule describes, we now estimate that FY 1992 outlier payments will equal 3.84 percent of total DRG payments (exclusive of indirect teaching and disproportionate share payments) and 4.0 percent of total payments under the prospective payment system for operating costs. The outlier payment percentage in FY 1993 is estimated to be 5.1 percent. The percentage changes shown in column 3A reflect the additional outlier payments that we estimate would be made during FY 1993 under our outlier policy before making the changes to the day outlier calculations as described above compared to our estimate of FY 1992 outlier payments.

The effect is to increase average payments per case, overall, by 1.4 percent. Among the hospital groupings,

the effect is the greatest for those hospitals that receive a relatively high percentage of outlier payments. In terms of geographic location, the effect is larger for hospitals located in large urban areas—raising payments an average of 1.6 percent. The effect is smallest for rural hospitals—raising their payments by 0.6 percent. Among hospitals that receive additional payments or are grouped according to certain characteristics, hospitals with large teaching programs receive the largest payment increases. The increase averages about 2.0 percent.

The analysis by census division shows urban hospitals in the Middle Atlantic census division receiving the greatest increase in payments. Among hospitals within this census division, urban hospitals receive an average increase of 2.1 percent, the largest increase of all hospital groups, and rural hospitals would receive an average increase of 1.1 percent, the largest increase among rural groups. Thus, in column 3C, we see that the net effect of the difference between FY 1992 outlier payments and FY 1993 estimated payments including the outlier policy changes, is an increase in payments to hospitals in the Middle Atlantic census division of 0.9 percent for urban hospitals and 0.3 percent for rural hospitals.

E. Combined Effects of All Changes (Column 4)

In column 4 of Table I, we present the effects of all final changes for FY 1993 compared to estimated payments under policies in effect for FY 1992. In addition to the changes being implemented for DRG weights (presented in column 1), the effects of FY 1993 geographic reclassification decisions (presented in column 2), and the changes to outlier payments (presented in columns 3A, B, and C), we incorporate the update factors for hospitals located in urban and rural areas (2.55 percent for urban hospitals and 3.55 percent for rural hospitals), the phase-out of the MDH provision, and revisions to the wage index and cost of living adjustments. Although we have not explicitly analyzed these changes in this impact analysis, they are discussed in the addendum to the final rule and in the preamble. As explained in our introductory remarks to the quantitative analysis section, some changes cannot be captured because we lack either current or complete data. There may also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column

4 may not equal the sum of the previous columns plus the other variables we are able to identify.

At the national level, our simulation of the final FY 1993 prospective payment rates shows that the average payment to hospitals would increase 4.0 percent. Urban hospitals can expect an increase of 4.1 percent, with hospitals in the large urban areas receiving an increase of 4.1 percent and hospitals in the other urban areas receiving an increase of 4.2 percent. Hospitals in rural areas can expect an average increase in payments of 3.0 percent. The lower increase in rural hospital payments is attributable to the phase-out of the MDH provision and a smaller impact from the underpayment of outliers during FY 1992.

The analysis by census division shows that among urban hospitals, those in the West South Central census division are projected to receive an increase in payments per case of 5.0 percent, the largest increase of any census division. With the exception of hospitals in Puerto Rico, other projected increases range from 3.8 percent for hospitals in the Middle Atlantic division to 4.7 for the East South Central census division. Hospitals in Puerto Rico are

projected to receive average increases of 3.5 percent.

Among the rural areas, the Pacific census division will receive the largest increase in payments per case of 4.1 percent. The smallest increase is projected for the Middle Atlantic census division, where rural payments per case are projected to be 1.5 percent above FY 1992 levels.

Consistent with our expectations, reclassified hospitals will gain the most under the policies being implemented in this document. Hospitals that are being reclassified for the first time in FY 1993 will receive the largest payment gains, 8.2 percent, which is largely as a result of an increase of 4.4 percent directly attributable to their reclassification. In contrast, hospitals that were reclassified in FY 1992 and will be reclassified again in FY 1993 are projected to receive an average payment increase of 3.1 percent, which is below the national average increase. Hospitals that were reclassified in FY 1992 but will not be reclassified in FY 1993 can expect average increases amounting to only 0.8 percent. Again, the small increase is due largely to the drop in payments of 3.1 percent as a result of these hospitals not being reclassified in FY 1993.

Nonreclassified hospitals may expect increased payments amounting to about 3.8 percent.

Rural hospitals with fewer than 50 beds are projected to receive a payment increase of 2.0 percent, and rural hospitals with from 50 to 99 beds are projected to receive an average increase of 2.6 percent. The expiration of the MDH provision has an adverse impact on hospitals in both of these groups. Among MDHs, average payments per case during FY 1993 will be 4.0 percent lower than during FY 1992, because of the elimination of the hospital-specific rate option effective with cost reporting periods ending after March 31, 1993.

Table III presents the projected average payments per case for FY 1992 and FY 1993, for urban and rural hospitals, and for the different categories of hospitals shown in Table I. It compares the projected payments with the average estimated per case payments under policies that were effective October 1, 1991. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. Consequently, the last column in Table III is identical to the column 4 in Table I.

TABLE III.—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE
[FY 1992 Payments Compared To FY 1993 Payments]

	Number of hospitals	FY 1992 payments/ case	FY 1993 payments/ case	All changes ¹
By geographic location all hospitals.....	5,386	5,537	5,756	4.0
Large urban areas (populations over 1 million).....	1,474	6,510	6,775	4.1
Other urban areas (populations of 1 million or fewer).....	1,422	5,452	5,682	4.2
Rural areas.....	2,490	3,837	3,952	3.0
Urban hospitals.....	2,896	6,000	6,248	4.1
0-99 beds.....	682	4,230	4,385	3.7
100-199 beds.....	872	5,092	5,303	4.1
200-299 beds.....	612	5,556	5,788	4.2
300-499 beds.....	537	6,264	6,521	4.1
500 or more beds.....	193	7,723	8,047	4.2
Rural hospitals.....	2,490	3,837	3,952	3.0
0-49 beds.....	1,232	3,189	3,253	2.0
50-99 beds.....	761	3,529	3,621	2.6
100-149 beds.....	259	3,974	4,098	3.1
150-199 beds.....	123	4,031	4,176	3.6
200-499 beds.....	112	4,566	4,732	3.6
500 or more beds.....	3	6,026	6,236	3.5
Urban by region:				
New England.....	172	6,358	6,615	4.0
Middle Atlantic.....	456	6,572	6,823	3.8
South Atlantic.....	421	5,729	5,979	4.4
East north central.....	476	5,853	6,084	4.0
East south central.....	168	5,184	5,426	4.7
West north central.....	183	5,835	6,061	3.9
West south central.....	357	5,451	5,725	5.0
Mountain.....	113	5,865	6,116	4.3
Pacific.....	501	6,772	7,038	3.9
Puerto Rico.....	49	2,320	2,401	3.5
Rural by region:				
New England.....	56	4,538	4,713	3.9
Middle Atlantic.....	93	4,311	4,377	1.5
South Atlantic.....	340	4,038	4,163	3.1
East north central.....	344	3,846	3,957	2.9
East south central.....	298	3,424	3,540	3.4
West north central.....	564	3,553	3,634	2.3

TABLE III.—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared To FY 1993 Payments]

	Number of hospitals	FY 1992 payments/case	FY 1993 payments/case	All changes ¹
West south central.....	396	3,481	3,594	3.2
Mountain.....	237	4,110	4,255	3.5
Pacific.....	158	4,654	4,843	4.1
Puerto Rico.....	6	1,549	1,600	3.3
All hospitals.....	5,386	5,537	5,756	4.0
Large urban areas (populations over 1 million).....	1,628	6,390	6,656	4.2
Other urban areas (populations of 1 million or fewer).....	1,487	5,392	5,613	4.1
Rural areas.....	2,271	3,788	3,893	2.8
Teaching status:				
Non-teaching.....	4,345	4,632	4,812	3.9
Resident/bed ratio less than 0.25.....	811	6,068	6,306	3.9
Resident/bed ratio 0.25 or greater.....	230	9,357	9,755	4.2
Disproportionate share:				
Hospitals (DSH).....				
Non-DSH.....	3,734	5,013	5,208	3.9
Urban DSH:				
100 beds or more.....	1,161	6,629	6,901	4.1
Fewer than 100 beds.....	99	4,040	4,175	3.3
Rural DSH:				
Sole community (SCH).....	101	3,645	3,766	3.3
Referral centers (RRC).....	46	4,614	4,795	3.9
Other rural DSH hospitals:				
100 beds or more.....	66	3,500	3,561	1.7
Fewer than 100 beds.....	179	3,029	3,113	2.8
Urban teaching and DSH:				
Both teaching and DSH.....	561	7,517	7,825	4.1
Teaching and no DSH.....	429	6,205	6,453	4.0
No teaching and DSH.....	699	5,315	5,533	4.1
No teaching and no DSH.....	1,426	4,873	5,083	4.3
Rural hospital types:				
Non special status.....	983	3,348	3,452	3.1
RRC.....	180	4,396	4,569	3.9
SCH.....	561	3,849	3,995	3.8
Medicare-dependent (MDH).....	501	3,290	3,157	-4.0
SCH and RRC.....	46	4,664	4,838	3.7
SCH or MDH.....	1,108	3,815	3,875	1.6
Type of ownership:				
Voluntary.....	3,212	5,691	5,913	3.9
Proprietary.....	729	5,055	5,288	4.6
Government.....	1,445	5,114	5,310	3.8
Medicare util: percent of days				
0-25.....	293	7,213	7,507	4.1
25-50.....	1,782	6,241	6,499	4.1
50-65.....	2,201	5,020	5,218	4.0
Over 65.....	865	4,526	4,658	2.9
Unknown.....	245	5,822	6,094	4.7

Hospitals reclassified by the Medicare Geographic Classification Review Board

Reclassification status during FY 1992 and FY 1993:				
Reclass. FY92 and FY93.....	849	4,845	4,993	3.1
Reclass. FY93 only.....	344	5,201	5,626	8.2
Reclass. FY92 only.....	80	4,973	5,011	0.8
FY93 reclassifications:				
All hospitals				
Reclassified.....	1,193	4,955	5,187	4.7
Nonreclassified.....	4,143	5,716	5,932	3.8
All urban hospitals:				
Reclassified.....	370	5,764	6,079	5.5
Nonreclassified.....	2,526	6,039	6,276	3.9
All rural hospitals:				
Reclassified.....	823	4,137	4,287	3.6
Nonreclassified.....	1,617	3,460	3,531	2.1
Other reclassified:				
(Section 1886(D)(8)(B)).....	50	4,284	4,446	3.8

¹ Percentage changes shown in the column are taken from Table I, column 4. Because the dollar amounts shown in this table are rounded to the nearest whole dollar, percentage changes computed on the basis of these amounts will differ slightly from those presented in the last column of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

An impact analysis of the capital prospective payment system must control for the two transitional payment methods (the hold-harmless method and the fully prospective payment method) and accurately forecast FY 1993 asset acquisitions and disposals. Our analysis is limited by the lack of hospital-specific data on future hospital capital investments. The lack of hospital-specific data limits our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the actual hospital capital growth rate for an individual hospital.

- Moreover, our policy of recognizing certain obligated capital as old capital complicates the problem of projecting future capital-related costs for individual hospitals. With the changes we are making to § 412.302(c) in this final rule, a hospital will have until the later of October 1, 1992 or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system to notify its intermediary that it has obligated capital. The intermediary will make its determination as to whether the obligated capital will qualify as old capital by the later of the end of the hospital's first cost reporting period under the capital prospective payment system or 9 months from the notification date. Since we do not have information on what proportion of an individual hospital's future capital spending will qualify as old capital, we cannot accurately project how an individual hospital will be affected by the transition payment policies.

Prior to this final rule, we had only limited information on which transition payment method would be applicable to an individual hospital. Limited information on initial payments under the capital prospective payment system coupled with an inability to accurately forecast FY 1993 asset acquisition meant that any projection of capital-related costs could be very inaccurate for individual hospitals. We concluded that a cross-sectional impact analysis using the usual prospective payment system hospital groupings (for example, urban or rural, teaching or nonteaching, etc.) that would rely on individual hospital

projections from prior cost reports would not be representative. Instead, in the August 30, 1991 final rule we presented the estimated impact of the capital prospective payment system using the results of the FY 1992 actuarial model that distinguished between high capital cost and low capital cost hospitals only.

Although we integrated hospital-specific data into the proposed FY 1993 actuarial model, the data were still sufficiently limited that we continued to present only the effects of the FY 1993 capital payment policies by payment methodology category in the impact analysis for the June 4, 1992 proposed rule. In Table IV of this final rule, we continue to present the redistributive effects that are expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals in FY 1993. In addition, we believe that we have now integrated sufficient hospital-specific information into our actuarial model to project with more confidence the impact of the FY 1993 capital payment policies by the usual prospective payment system hospital groupings. We caution that while we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system for some hospitals and base year cost report data for most of the remaining hospitals, we need to randomly generate the change in old capital costs, the new capital ratio, and obligated costs for individual hospitals. This means that we continue to be unable to accurately predict an individual hospital's FY 1993 capital costs; however, with the more recent data on the experience to date under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings. If a grouping has a limited number of hospitals, the results may not be representative of the actual hospitals in the grouping. We combined these small groupings with other hospital groupings where appropriate. We present the transition payment methodology by hospital grouping in Table V. In Table VI we present the results of the cross-sectional analysis using the results of our actuarial model. This table presents aggregate impact of the FY 1993 payment policies. In Table VII, we present a simulation of payments based on 100 percent of the Federal rate. This simulation shows the average percentage change in the Federal rate attributable to the updated rate and changes in payment adjustments.

B. Projected Impact By Transition Payment Methodology

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1992 through FY 1993 using an actuarial model. The FY 1993 actuarial model, described in appendix B of this **Federal Register** document, integrates actual data from individual hospitals with randomly generated amounts developed from the results of the capital acquisition model used in the August 30, 1991 final rule. We have available more recent capital cost data from cost reports beginning in FY 1989 and FY 1990 through the Hospital Cost Reporting Information System (HCRIS), interim payment data for hospitals already receiving capital prospective payments through PRICER, and limited capital audit data from intermediary reports. However, we do not have individual hospital data on old capital changes, new capital formation, and obligated capital. Because we can combine actual data for individual hospitals with the results from the capital acquisition model, we need to generate only the old and new capital changes and obligated capital randomly. All Federal rate payment parameters, which were randomly assigned by the capital acquisition model in the FY 1992 final rule, are assigned in the FY 1993 model to the applicable hospital.

For purposes of this impact analysis, the FY 1993 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

Fiscal year	Average percentage increase in capital costs per discharge
1992	6.56
1993	9.58

- The Medicare case mix index will increase by 2 percent annually.
- The Federal capital rate as well as the hospital-specific rate is updated by the two-year moving average increase in Medicare capital costs per case, net of case-mix change, between FY 1988 and FY 1990. The FY 1993 update is 6.07 percent (see Addendum, part III).
- Consistent with the budget neutrality constraints provided in section 4001(b) of Pub. L. 101-508, estimated aggregate Medicare payments for capital costs in FY 1993 equal 90 percent of total Medicare inpatient

capital costs. The budget neutrality adjustment factor is applied to the Federal and hospital-specific rates only and not to the hold-harmless payment for old capital.

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1992 to FY

1993. To show the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals, we are presenting in Table IV the results of our simulation separately by payment category. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and

the applicable Federal rate, it is paid under the fully prospective payment methodology in FY 1992. A high cost hospital is a hospital that, based on its initial hospital-specific rate, is paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY

Type of hospital	Percent of hospitals	FY 1993 percent of discharges	FY 1993 percent of capital costs	FY 1993 percent of capital payments
Low Cost Hospital.....	65	60	44	47
High Cost Hospital.....	35	40	56	53

A low cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use. If the redetermined hospital-specific rate is

greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital would become a hold-harmless payment hospital as a result of a redetermination in FY 1992 or FY 1993, we have continued to show these hospitals as low cost hospitals in Table IV. The

following table shows our estimate of the percentage of low capital cost hospitals that would be paid under the hold-harmless payment methodology through a hospital-specific rate redetermination and the basis of their payment under hold-harmless payment methodology:

Fiscal year	Percent of low cost fully prospective hospitals that qualify as hold-harmless	Of these, percent that are paid:	
		100% federal rate	Hold-harmless
1992.....	0.7	9	91
1993.....	0.7	5	95

Assuming no behavioral changes in capital expenditures, Table IV displays

the percentage change in payments from FY 1992 to FY 1993 using the above described actuarial model.

TABLE IV.—IMPACT OF FY 1993 CHANGES ON PAYMENTS PER DISCHARGE

	No. of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
FY 1992									
Low Cost Hospitals.....	3,474	5,814,013	\$64.55	10.03	\$393.49	\$3.38	\$3.12	\$464.54	
Fully Prospective.....	3,090	5,334,882	64.77	10.00	397.93		2.57	465.26	
Rebase—Fully Prospective.....	362	446,832	59.42	10.00	368.97		9.38	437.77	
Rebase—100% Federal Rate.....	2	2,949	523.34	100.00				523.34	
Rebase—Hold Harmless.....	20	29,350	57.32	9.31		670.16	8.34	735.82	
High Cost Hospitals.....	1,886	3,849,477	323.54	48.50		481.71	6.62	811.86	
100% Federal Rate.....	556	1,406,141	696.94	100.00				696.94	
Hold Harmless.....	1,330	2,443,336	108.64	16.72		758.94	10.42	878.00	
Total Hospitals.....	5,360	9,663,490	167.72	25.69	236.74	193.93	4.51	602.90	
FY 1993									
Low Cost Hospitals.....	3,474	5,814,013	\$132.77	20.12	\$358.92	\$3.57	\$9.11	\$504.37	8.57
Fully Prospective.....	3,090	5,334,882	132.89	20.00	362.96		6.10	501.95	7.89
Rebase—Fully Prospective.....	362	446,832	121.89	20.00	336.73		42.28	500.90	14.42
Rebase—100% Federal Rate.....	1	1,040	528.00	100.00				528.00	0.89
Rebase—Hold Harmless.....	21	31,259	253.89	40.23		663.64	48.80	966.33	31.33
High Cost Hospitals.....	1,886	3,849,477	355.36	51.97		476.68	13.68	845.72	4.17
100% Federal Rate.....	541	1,353,931	696.80	100.00				696.80	-0.02
Hold Harmless.....	1,345	2,495,546	170.11	25.14		735.30	21.10	926.51	5.52

TABLE IV.—IMPACT OF FY 1993 CHANGES ON PAYMENTS PER DISCHARGE—Continued

	No. of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
Total Hospitals.....	5,360	9,663,490	221.44	33.07	215.95	192.03	10.93	640.35	6.21

Under section 1886(g)(1) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 are to equal 90 percent of what would have been payable on a reasonable cost basis in each year, respectively. (See Addendum, Part III for a full discussion of the budget neutrality provision.) We project that in FY 1992 aggregate payments under the capital prospective payment system are higher than 92.85 percent of reasonable costs. Taking the phase-in of the capital prospective payment system into account, this represents excessive capital payments of approximately \$90 million. To achieve budget neutrality in FY 1993, we estimate there should be an aggregate 6.2 percent increase in Medicare capital payments over the FY 1992 payments.

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average case-weighted increase in payments of 8.6 percent, and high capital cost hospitals will experience an average increase of 4.2 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 10 percent to 20 percent and the hospital-specific rate payment percentage will decrease from 90 to 80 percent in FY 1993.

The Federal rate payment percentage for a hospital paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs of total capital costs. We estimate average Federal rate payment percentage for those hospitals receiving a hold-harmless payment for old capital will increase from 16.7 percent to 25.1 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will change only marginally.

We are making no changes in our exceptions policies in FY 1993. As a result, the minimum payment levels will be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that there will be a 96 percent increase in exceptions payments in FY 1993. As a result, exceptions will increase from 0.7 percent to 1.7 percent total capital payments. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1993 EXCEPTIONS PAYMENTS

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost.....	294	50.1
High Capital Cost.....	235	49.9
Total.....	529	100.0

C. Distribution of Hospitals By Payment Methodologies

Table V presents a cross-sectional summary of hospitals by capital prospective payment methodology. This distribution is not generated by our actuarial model. Rather, it is based on the June 30, 1992 update of the Provider-Specific File used by intermediaries to make interim capital payments using the PRICER program, audit information reported by intermediaries, and cost report data from fiscal years 1988, 1989, and 1990.

As we explain in appendix B, we were not able to determine a hospital specific rate for 26 of the 5,386 hospitals in our data base. Consequently, the payment methodology distribution is based on

5,360 hospitals. In the June 4, 1992 proposed rule, we were able to present interim capital payment data from our Provider Specific File for only 44 percent of the hospitals. Therefore, the data in Table V of the proposed rule was not fully representative of the payment methodologies that will be applicable to the full set of hospitals. In the impact analysis for this final rule, the data from 5,360 should be fully representative of the payment methodologies that will be applicable to hospitals.

In Table V, we are presenting the distribution of the capital payment methodologies for teaching hospitals in terms of the resident-to-bed ratio specifically so that readers may compare these analysis with those for the prospective payment system for operating costs. Also, we have not yet developed a break point for distinguishing heavy teaching involvement from light teaching involvement using the resident-to-average-daily-census ratio that is comparable to the break point developed for the resident-to-bed ratio (resident-to-bed ratios less than .25 or ratios equal to or greater than .25). Although we are classifying teaching hospitals according to their resident-to-bed ratio for display purposes, for our Federal rate payment simulations, we have computed the indirect medical education adjustment factor using the ratio of resident-to-average daily census.

The distribution of hospitals by payment methodology is provided by: (1) Geographic location, (2) region, and (3) payment classification. This provides an indication of what percentage of hospitals within a particular hospital grouping is under the fully prospective payment methodology and under the hold-harmless methodology. The information is based on the 5,360 hospitals with interim capital payment data on our data base.

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold- harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals.....	5,360	25.5	10.1	64.4
Large urban areas (populations over 1 million).....	1,464	33.4	13.3	53.3
Other urban areas (populations of 1 million or fewer).....	1,410	30.4	13.4	56.2
Rural areas.....	2,486	18.1	6.4	75.5
Urban hospitals.....	2,874	31.9	13.3	54.8
0-99 beds.....	665	32.3	8.3	59.4
100-199 beds.....	868	39.3	12.2	48.5
200-299 beds.....	611	30.8	16.9	52.4
300-499 beds.....	537	24.6	15.8	59.6
500 or more beds.....	193	21.2	17.6	61.1
Rural hospitals.....	2,486	18.1	6.4	75.5
0-49 beds.....	1,228	13.2	3.5	83.3
50-99 beds.....	761	21.3	7.6	71.1
100-149 beds.....	259	24.7	13.9	61.4
150-199 beds.....	123	26.8	7.3	65.9
200 or more beds.....	115	24.3	11.3	64.3
By Region:				
Urban by Region.....	2,874	31.9	13.3	54.8
New England.....	172	15.7	8.7	75.6
Middle Atlantic.....	450	19.8	16.2	64.0
South Atlantic.....	419	40.8	13.8	45.3
East North Central.....	476	21.2	13.4	65.3
East South Central.....	168	46.4	11.9	41.7
West North Central.....	183	27.3	13.7	59.0
West South Central.....	353	56.7	16.7	26.6
Mountain.....	112	38.4	12.5	49.1
Pacific.....	494	28.9	10.7	60.3
Puerto Rico.....	47	31.9	4.3	63.8
Rural by Region.....	2,486	18.1	6.4	75.5
New England.....	56	7.1	8.9	83.9
Middle Atlantic.....	91	12.1	7.7	80.2
South Atlantic.....	340	24.7	6.8	68.5
East North Central.....	344	11.6	6.4	82.0
East South Central.....	298	25.2	8.7	66.1
West North Central.....	564	10.6	5.0	84.4
West South Central.....	394	26.6	8.1	65.2
Mountain.....	237	16.0	3.0	81.0
Pacific.....	156	19.9	5.1	75.0
By Payment Classification:				
All hospitals.....	5,360	25.5	10.1	64.4
Large urban areas (populations over 1 million).....	1,618	32.9	13.4	53.6
Other urban areas (populations of 1 million or fewer).....	1,475	29.5	12.7	57.8
Rural areas.....	2,267	17.6	6.0	76.4
Teaching Status:				
Non-teaching.....	4,321	26.2	9.3	64.5
Resident/bed ratio less than 0.25.....	809	23.7	13.7	62.5
Resident/bed ratio 0.25 or greater.....	230	18.7	12.2	69.1
Disproportionate share hospitals (DSH):				
Non-DSH, rural.....	2,267	17.6	6.0	76.4
Non-DSH, urban, fewer than 100 beds.....	842	31.1	8.3	60.6
Urban DSH, 100 beds or more.....	2,251	31.4	14.9	53.8
Urban teaching and DSH:				
Both teaching and DSH.....	933	22.2	14.1	63.7
Teaching and no DSH.....	55	29.1	5.5	65.5
No teaching and DSH.....	1,318	37.9	15.4	46.7
No teaching and no DSH.....	787	31.3	8.5	60.2
Rural Hospital Types:				
Non-special status hospitals.....	1,034	16.0	6.8	77.3
RRC.....	180	23.9	13.3	62.8
SCH.....	561	22.8	2.9	74.3
Medicare-dependent hospitals (MDH).....	443	11.5	5.2	83.3
SCH or MDH.....	1,050	18.1	4.0	77.9
Type of Ownership:				
Voluntary.....	3,186	24.0	11.7	64.2
Proprietary.....	729	52.8	13.0	34.2
Government.....	1,445	14.9	5.1	80.1
Medicare Utilization as a Percent of Inpatient Days:				
0-25.....	293	27.3	8.2	64.5
25-50.....	1,782	28.3	11.3	60.3
50-65.....	2,201	23.3	9.9	66.8
Over 65.....	865	20.7	8.7	70.6

The distribution of hospitals by capital payment methodology is somewhat different than the distribution of low and high capital cost hospitals in the August 30, 1991 final rule. In the August 1991 final rule, we anticipated that 71 percent of hospitals would receive payment on a fully prospective basis. Table V indicates that 64.4 percent of hospitals are fully prospective. As expected, a relatively higher percentage of rural and governmental hospitals are being paid on the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. More than 75 percent of rural hospitals and 80 percent of governmental hospitals are paid under the fully prospective payment methodology compared to an average of 64.4 percent of all hospitals. In contrast, only 34.2 percent of the proprietary hospitals are being paid under the fully prospective payment methodology. This is the only group of hospitals that has a majority of hospitals paid under the hold harmless methodology. As we noted in the August 30, 1991 final rule (56 FR 43430), we found that about 62.7 percent of proprietary hospitals have a capital cost per case above the national average cost per case.

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 1993 actuarial model to estimate the potential impact of the FY 1993 operating and capital payment policy changes on total capital payments per case using a universe of 5,360 hospitals. The individual hospital payment parameters are taken from the best available data, including: FY 1991 MEDPAR bills, the June 30, 1992 update to the Provider-Specific File, and cost report data for cost reporting periods beginning in FY 1990. Table VI presents a comparison of payments per case for FY 1992 and FY 1993. It also presents the portion of the total percentage change in payments that can be attributed to Federal rate changes. Federal rate changes include the 0.41 percent increase in the Federal rate, a 2.0 percent increase in case mix, changes in the adjustments to the Federal rate (e.g., wage index corrections), and reclassifications by the Medicare Geographic Classification Review Board. The residual increase over the portion attributable to Federal rate changes can be attributed to the effects of transition changes, which include: the change from 10% to 20% in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold harmless

hospitals, changes in old capital (e.g., obligated capital coming on line), redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) payment classification, and (3) payment region.

The simulation results show that, on average, payments per case can be expected to increase by 6.2 percent in FY 1993. The results also show that a 0.7 percent increase is attributable to Federal rate changes, leaving 5.5 percent attributable to the effects of transition changes and budget neutrality.

By geographic location, rural hospitals can be expected to experience a higher rate of increase than urban hospitals (6.7 percent compared to 6.1 percent). Urban hospitals will gain slightly more than rural hospitals (0.7 percent compared to 0.6 percent) from the Federal rate changes. However, rural hospitals will gain more than urban hospitals (6.1 percent to 5.4 percent) from the effects of transition changes. Since more rural hospitals than urban hospitals (75.5 percent to 54.8 percent) are paid on a fully prospective basis, the greater gain of rural hospitals from the Federal rate changes must result to some degree from the increase in the percentage of the Federal rate portion.

By region, rural hospitals of the Pacific region have the highest rate of increase (8.5 percent, of which 0.5 percent is due to Federal rate changes and 8.0 percent to the effects of transition changes). Urban hospitals of the West South Central region will have the lowest rate of increase (4.0 percent, of which 0.8 percent is due to Federal rate changes and 3.2 percent is due to effects of transition changes).

By type of ownership, government hospitals are projected to have the highest rate of increase (8.5 percent, of which 0.8 percent is due to Federal rate changes and 7.7 percent to the effects of transition changes). Significantly, government hospitals, which have the highest percentage of hospitals paid under the fully prospective methodology (80.1 percent) by type of ownership, can be expected to do much better than proprietary hospitals, which have the highest percentage of hospitals paid hold-harmless (52.8 percent). Payments to proprietary hospitals will increase 4.8 percent and payments to voluntary hospitals will increase 6.1 percent.

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review Board (MGCRB). Fiscal year 1992 is the first year that hospitals were reclassified as a result of decisions by the MGCRB. Hospitals may apply for reclassification for the purpose of obtaining a higher wage index value,

standardized payment amount or both a higher standardized payment amount and wage index value. Although there is no difference with respect to the Federal capital rate, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor since it is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1993 compared to FY 1992, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1993 reclassifications, we are indicating those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both factors. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Reclassified hospitals as a whole can be expected to realize a 6.8 percent increase, of which 0.9 percent is attributable to the Federal rate changes and 5.9 percent is attributable to the effects of transition changes. Nonreclassified hospitals will gain less than reclassified hospitals overall (6.1 percent). While nonreclassified hospitals will gain slightly less (0.7 percent to 0.9 percent) than reclassified hospitals from the Federal rate changes, they will gain significantly less (5.4 percent to 5.9 percent) than the reclassified hospitals from the effects of transition changes. In other words, more (0.5 percent to 0.2 percent) of the greater gain for reclassified hospitals derives from the effects of transition changes than from the Federal rate changes (including the effects of their reclassifications). This result is not unexpected because (1) the comparison is to FY 1992 payments, which already reflect the results of reclassification for most hospitals and (2) a higher percentage of reclassified hospitals are paid under the fully prospective payment methodology. Hospitals reclassified by the Medicare Geographic Classification Review Board only during FY 1993 can be expected to realize a much larger increase (7.8 percent total) than other reclassified hospitals. Of that 7.8 percent aggregate increase for these hospitals, 1.8 percent can be attributed to Federal rate changes, and 6.0 percent is attributable to transition effects. Hospitals reclassified during both FY

1992 and FY 1993 can be expected to experience a 6.4 percent increase, of which 0.5 percent is attributable to Federal rate changes and 5.9 percent is attributable to the effects of transition

changes. Hospitals reclassified during FY 1992 only are expected to realize a much smaller increase (3.4 percent, net of a 0.1 percent decrease from Federal rate changes) than other reclassified

hospitals in FY 1993 as they lose the higher payments from their geographic reclassification during FY 1992.

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1992 Payments Compared to FY 1993 Payments]

	No. of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals.....	5,360	603	640	6.2	0.7
Large urban areas (populations over 1 million).....	1,484	711	757	6.4	0.7
Other urban areas (populations of 1 million or fewer).....	1,410	605	640	5.7	0.8
Rural areas.....	2,486	402	429	6.7	0.6
Urban hospitals.....	2,874	660	700	6.1	0.7
0-99 beds.....	665	557	587	5.4	0.5
100-199 beds.....	868	618	658	6.1	0.6
200-299 beds.....	611	639	678	6.1	0.7
300-499 beds.....	537	653	692	5.9	0.7
500 or more beds.....	193	781	833	6.7	0.8
Rural hospitals.....	2,486	402	429	6.7	0.6
0-49 beds.....	1,228	282	308	8.0	0.5
50-99 beds.....	761	373	401	7.4	0.6
100-149 beds.....	259	449	474	5.6	0.7
150-199 beds.....	123	432	465	7.6	0.5
200 or more beds.....	115	498	522	4.9	0.7
By Region:					
Urban by Region.....	2,874	660	700	6.1	0.7
New England.....	172	593	638	7.5	0.9
Middle Atlantic.....	450	654	694	6.1	0.9
South Atlantic.....	419	674	714	5.9	0.7
East North Central.....	476	608	652	7.2	0.6
East South Central.....	168	606	639	5.5	0.9
West North Central.....	183	651	684	5.0	0.5
West South Central.....	353	789	821	4.0	0.8
Mountain.....	112	697	729	4.6	0.6
Pacific.....	494	715	769	7.6	0.6
Puerto Rico.....	47	257	274	6.5	0.4
Rural by Region.....	2,486	402	429	6.7	0.6
New England.....	56	395	423	7.1	0.6
Middle Atlantic.....	91	397	428	7.9	0.7
South Atlantic.....	340	447	468	4.7	0.6
East North Central.....	344	380	411	8.2	0.7
East South Central.....	298	384	405	5.4	0.6
West North Central.....	564	348	373	7.4	0.7
West South Central.....	394	402	431	7.3	0.9
Mountain.....	237	449	480	7.0	0.2
Pacific.....	156	487	528	8.5	0.5
By Payment Classification:					
All hospitals.....	5,360	603	640	6.2	0.7
Large urban areas (populations over 1 million).....	1,818	701	746	6.4	0.7
Other urban areas (populations of 1 million or fewer).....	1,475	595	629	5.7	0.7
Rural areas.....	2,267	394	421	6.9	0.6
Teaching Status:					
Non-teaching.....	4,321	546	577	5.7	0.7
Resident/bed ratio less than 0.25.....	809	632	672	6.4	0.8
Resident/bed ratio 0.25 or greater.....	230	859	925	7.7	0.8
Disproportionate share hospitals (DSH):					
Non-DSH, rural.....	2,267	394	421	6.9	0.6
Non-DSH, urban, fewer than 100 beds.....	842	533	563	5.6	0.5
Urban DSH, 100 beds or more.....	2,251	662	703	6.1	0.7
Urban teaching and DSH:					
Both teaching and DSH.....	833	693	740	6.8	0.8
Teaching and no DSH.....	55	614	653	6.3	0.4
No teaching and DSH.....	1,318	630	663	5.4	0.7
No teaching and no DSH.....	787	529	558	5.6	0.5
Rural Hospital Types:					
Non special status hospitals.....	1,034	345	371	7.5	0.6
RRC.....	180	476	504	5.9	0.8
SCH.....	561	409	439	7.4	0.3
Medicare-dependent hospitals (MDH).....	443	304	327	7.8	0.7
SCH or MDH.....	1,050	390	418	7.1	0.4

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared to FY 1993 Payments]

	No. of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes	Portion attributable to Federal rate change
Hospitals Reclassified by the Medicare Geographic Classification Review Board					
Reclassification Status During FY92 and FY93:					
Reclassified During Both FY92 and FY93	849	504	536	8.4	0.5
Reclassified During FY93 Only	344	560	604	7.8	1.8
Reclassified During FY92 Only	80	519	536	3.4	-0.1
FY93 Reclassifications:					
All Reclassified Hospitals	1,193	521	557	6.8	0.9
All Nonreclassified Hospitals	4,117	628	666	6.1	0.7
All Urban Reclassified Hospitals	370	603	647	7.2	1.1
Urban Nonreclassified Hospitals	2,504	669	709	6.0	0.7
All Reclassified Rural Hospitals	823	442	470	6.4	0.8
Rural Reclassified Hospitals	1,613	354	379	7.1	0.4
Other Reclassified Hospitals:					
(Section 1886(D)(8)(B))	50	447	477	6.6	0.6
Type of Ownership:					
Voluntary	3,186	612	649	6.1	0.7
Proprietary	729	712	746	4.8	0.6
Government	1,445	476	517	8.5	0.8
Medicare Utilization as a Percent of Inpatient Days:					
0-25	293	648	698	7.7	0.6
25-50	1,782	665	707	6.3	0.8
50-65	2,201	553	587	6.2	0.7
Over 65	865	549	578	5.2	0.7

E. Cross-Sectional Analysis of Changes in the Federal Rate

The analysis in Table VII examines the impact of following changes in the Federal Rate set forth in this final rule—

- The effects of the annual reclassification of DRGs and the recalibration of the DRG weights required by section 1886(d)(4)(c) of the Act (column 4).
- The effects of hospital reclassifications by the MGCRCB for FY 1993 (column 5).
- The net effect of outlier changes (column 6), that is, the additional outlier payments that we estimate will be made during FY 1993 compared to our estimate of FY 1992 outlier payments, the increase in outlier payment levels, and the effect of the outlier payment changes (using a marginal cost factor of .55 and the arithmetic mean to calculate day outlier payments).
- The effects of all changes, including those separately displayed in columns 4, 5, and 6; reflects update and budget neutrality factors.

To estimate the impact of DRG changes, changes due to geographic reclassification, and outlier changes, we simulated payments based on 100% of the Federal rate. Thus, the simulation in Table VII is not representative of changes in capital prospective payment system payments from FY 1992 to FY 1993. Rather, it reflects the percentage change in payments for hospitals receiving 100% of the Federal rate. For other hospitals, it reflects the percentage change in the Federal rate portion of the

payments, holding the proportion of the Federal rate payment constant. Unlike the Federal rate payment change in Table VI, the analysis in Table VII does not include any increase in Federal rate payments attributable to anticipated increases in the case-mix index.

In order to present the effects of the separate policy changes displayed in columns 4, 5, and 6, we added each change incrementally, so that the percentages in each column represent the differences in payment relative to the previous column. The baseline for comparison is an FY 1993 system absent any of the changes above. For example, column 4 displays the impact of DRG recalibration and reclassification relative to estimated FY 1993 payments absent these changes. Similarly, column 5 examines the impact of the changes resulting from geographic reclassifications over and above the changes resulting from the DRG reclassifications and recalibration. Column 6 displays the impact of the outlier changes after accounting for the DRG recalibration and geographic reclassification changes. Column 7 displays the combined changes from the previous columns, as well as the effects of the update and budget neutrality factors. This column compares estimated FY 1993 Federal rate payments to estimated FY 1992 Federal rate payments. Thus, the last column is the only one which reflects the effects of all quantifiable policy changes on simulated FY 1993 Federal rate payments.

The table shows that Federal rate payments can be expected to increase 2.0 percent overall prior to consideration of any increase in the case-mix index. Of this total increase, 1.4 percent is due to the outlier changes. DRG recalibration and geographic reclassifications produce no overall effect. The residual over and above the 1.4 percent increase due outlier changes is mostly due to the 0.41 percent increase in the Federal rate.

The table also shows the distributional effects of the changes in Federal rate payments from DRG recalibration, changes due to the geographic adjustment factor and reclassifications, and changes in the outlier payment policy. The DRG changes are expected to produce only minimal effects on the distribution of Federal rate payments. The highest gain from recalibration is projected at 0.4 percent (for urban Middle Atlantic hospitals). The largest loss from recalibration is projected at -0.3 percent (for four categories of hospitals).

The geographic adjustment factor and reclassification changes are in relation to the FY 1992 reclassifications. They are expected to produce only minor effects (from -0.6 percent to 0.5 percent) outside the categories of reclassified hospitals. Among reclassified hospitals, those reclassified during FY 1993 only are expected to experience the largest increase (4.4 percent) from the effects of reclassification of any category.

Hospitals reclassified only during FY 1992 will experience the largest decline (-3.5 percent) from the effects of reclassification. That decline is attributable to the loss of the higher payments from the reclassification in FY 1992. The small (-0.6 percent) decline in payments for hospitals reclassified both during FY 1992 and FY 1993 is due to the effects of the budget neutrality adjustment for changes in the geographic adjustment factor and a decrease in their geographic adjustment factor values. These changes are largely attributable to the additional geographic reclassifications in FY 1993. Reclassified hospitals as a group are expected to experience a 1.0 percent increase from the effects of reclassifications. Nonreclassified hospitals as a group will experience a decline of -0.3 percent

from the effects of reclassifications. Relatively more urban hospitals were reclassified for the first time for FY 1993. As a result, urban reclassified hospitals will experience a larger increase in payments (1.4 percent) than rural reclassified hospitals (0.5 percent).

Reclassified hospitals will also experience higher than average overall Federal rate increases. In fact, hospitals reclassified during FY 1993 only will experience the highest overall Federal rate increase (6.4 percent) of any category. All reclassified hospitals will receive on average a higher overall increase (2.7 percent) than all nonreclassified hospitals (1.8 percent). As a group, therefore, reclassified hospitals are projected to do better than nonreclassified hospitals not only from the effects of reclassifications, but also

from the effects of other changes to the Federal rate.

Urban hospitals will experience larger increases in payments than rural hospitals from the outlier changes (1.5 percent to 0.7 percent). This is because rural hospitals have fewer outliers than urban hospitals; therefore, rural hospitals will not receive as much benefit from the increase in outlier payments. The lower projected rate of increase for urban hospitals in Region II (Middle Atlantic) compared to other urban hospitals is also explained by the fact that urban hospitals in Region II have proportionately more day outliers than other hospitals. The shift in payments from day outliers to cost outliers therefore has a greater impact on them.

TABLE VII.—HEALTH CARE FINANCING ADMINISTRATION 1993 FINAL CAPITAL PAYMENT SIMULATION BY GEOGRAPHIC LOCATION

	(1) Number of hospitals	(2) Payment per case FY92	(3) Payment per case FY93	(4) Recalibration change	(5) reclassification change	(6) Sum of outlier changes	(7) All changes
All hospitals	5,386	632	644	0.0	0.0	1.4	2.0
Large urban areas (populations over 1 million)	1,474	735	749	0.0	-0.1	1.4	2.0
Other urban areas (populations of 1 million or fewer)	1,422	626	639	0.0	0.1	1.5	2.2
Rural areas	2,490	447	453	-0.1	0.1	0.7	1.3
Urban hospitals	2,896	682	696	0.0	0.0	1.5	2.1
0-99 beds	682	501	510	-0.1	0.0	1.3	1.8
100-199 beds	872	593	607	0.1	0.1	1.5	2.3
200-299 beds	612	645	660	0.0	0.1	1.5	2.2
300-499 beds	537	710	724	0.0	-0.1	1.5	2.0
500 or more beds	193	838	855	-0.1	0.0	1.5	2.0
Rural hospitals	2,490	447	453	-0.1	0.1	0.7	1.3
0-49 beds	1,232	374	376	-0.2	0.1	0.2	0.7
50-99 beds	761	415	420	-0.2	0.1	0.5	1.1
100-149 beds	259	465	471	-0.1	0.0	0.9	1.4
150-199 beds	123	471	478	-0.1	0.1	0.7	1.4
200 or more beds	115	531	540	0.0	0.1	1.1	1.8
Urban by region:							
New England	172	714	724	-0.2	0.3	0.8	1.5
Middle Atlantic	456	730	743	0.4	0.0	0.7	1.7
South Atlantic	421	657	674	-0.1	0.0	2.0	2.6
East North Central	476	666	678	-0.1	-0.1	1.4	1.8
East South Central	168	593	609	0.1	-0.1	2.2	2.8
West North Central	183	675	688	-0.1	-0.2	1.5	1.8
West South Central	357	629	651	0.1	0.3	2.4	3.4
Mountain	113	687	704	-0.2	-0.1	2.1	2.5
Pacific	501	769	782	-0.3	0.0	1.5	1.8
Puerto Rico	49	277	282	0.2	-0.2	1.1	1.7
Rural by region:							
New England	56	519	522	-0.2	-0.4	0.6	0.7
Middle Atlantic	93	496	499	0.0	-0.3	0.3	0.6
South Atlantic	340	471	478	0.0	-0.3	1.1	1.4
East North Central	344	450	456	-0.1	0.3	0.8	1.4
East South Central	298	403	407	0.0	-0.2	0.7	1.1
West North Central	564	416	421	-0.2	0.5	0.4	1.4
West South Central	396	410	417	-0.1	0.5	0.8	1.7
Mountain	237	466	470	-0.2	-0.4	0.8	0.9
Pacific	156	537	545	-0.2	0.5	0.7	1.6
Puerto Rico	6	219	220	-0.1	-0.3	0.4	0.6
All hospitals	5,386	632	644	0.0	0.0	1.4	2.0
Large urban areas (populations over 1 million)	1,474	735	749	0.0	0.0	1.4	2.1
Other urban areas (populations of 1 million or fewer)	1,422	626	639	-0.1	0.0	1.5	2.1
Rural areas	2,490	447	453	-0.1	0.0	0.7	1.2
Teaching status:							
Non-teaching	4,345	546	557	0.0	0.1	1.4	2.1
Resident/bed ratio less than 0.25	811	692	704	0.0	-0.1	1.3	1.8
Resident/bed ratio 0.25 or greater	230	963	983	0.0	0.1	1.4	2.1
Disproportionate share hospitals (DSH):							
Non-DSH, rural	2,271	441	446	-0.1	0.0	0.7	1.2
Non-DSH, urban fewer than 100 beds	859	493	502	-0.1	0.1	1.2	1.8
Urban DSH 100 beds or more	2,256	689	704	0.0	0.0	1.5	2.1

TABLE VII.—HEALTH CARE FINANCING ADMINISTRATION 1993 FINAL CAPITAL PAYMENT SIMULATION BY GEOGRAPHIC LOCATION—Continued

	(1) Number of hospitals	(2) Payment per case FY92	(3) Payment per case FY93	(4) Recalibration change	(5) reclassification change	(6) Sum of outlier changes	(7) All changes
Urban teaching and DSH:							
Both teaching and DSH	934	763	778	0.0	-0.1	1.4	1.9
Teaching and no DSH	56	568	578	-0.3	-0.2	1.7	1.8
No teaching and DSH	1,322	610	624	0.0	0.1	1.7	2.4
No teaching and no DSH	803	489	498	-0.1	0.1	1.2	1.8
Rural hospital types:							
Non special status hospitals	1,038	407	410	-0.1	-0.3	0.6	0.8
RRC	180	508	517	-0.1	0.4	0.9	1.9
SCH	561	424	427	-0.1	-0.3	0.6	0.8
Medicare-dependent hospitals (MDH)	443	376	380	-0.2	0.3	0.4	1.1
SCH and RRC	46	513	520	0.0	-0.1	0.8	1.4
SCH or MDH	1,050	426	431	-0.1	-0.1	0.6	1.0
Type of ownership:							
Voluntary	3,212	650	662	0.0	0.0	1.3	1.8
Proprietary	729	596	614	0.0	0.0	2.4	3.0
Government	1,445	568	578	-0.1	0.2	1.1	1.9
Medicare utilization as a percent of inpatient days:							
0-25	293	752	765	0.2	0.0	1.1	1.8
25-50	1,782	698	712	-0.1	0.0	1.5	2.1
50-65	2,201	587	598	0.0	0.0	1.3	1.9
Over 65	865	536	546	0.0	0.0	1.3	1.8
Unknown	245	651	667	0.3	0.5	1.0	2.5
By Payment Classification							
Hospitals reclassified by the Medicare Geographic Classification Review Board reclassification status during FY92 and FY93							
Reclassified during both FY92 and FY93	849	564	569	0.0	-0.6	1.0	1.0
Reclassified during FY93 only	344	596	634	0.1	4.4	1.1	6.4
Reclassified during FY92 only	80	568	559	-0.1	-3.5	1.3	-1.6
FY93 reclassifications:							
All reclassified hospitals	1,193	574	589	0.0	1.0	1.0	2.7
All nonreclassified hospitals	4,143	650	661	0.0	-0.3	1.5	1.8
Urban reclassified hospitals	370	663	685	0.1	1.4	1.2	3.4
Urban nonreclassified hospitals	2,526	685	696	0.0	-0.2	1.5	1.9
Rural reclassified hospitals	823	484	493	-0.1	0.5	0.8	1.8
Rural nonreclassified hospitals	1,617	400	403	-0.1	-0.5	0.6	0.6
Other reclassified hospitals (section 1886(D)(8)(B))	50	510	519	-0.1	0.1	1.1	1.7

Appendix B: Technical Appendix on the Capital Acquisition Model and Budget Neutrality Adjustment

Section 1886(g)(1) of the Act requires that for FY 1992 through FY 1995 aggregate prospective payments for operating costs under section 1886(d) and prospective payments for capital costs under section 1886(g)(1) of the Act be reduced each year in a manner that results in savings equal to 10 percent of the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. Under § 412.352, the 10 percent savings is generated entirely from the capital prospective payments. A budget neutrality adjustment factor is applied to the Federal rate and hospital-specific rate so that total capital payments for FY 1992 through FY 1995 approximately equal 90 percent of Medicare inpatient capital costs in each year.

To calculate budget neutrality, the hold-harmless provision of the payment methodology requires that we identify old and new capital; that is, we must be able to project the rate at which old

capital will be depreciated and written off and at which new capital will be acquired and depreciated. (Old capital costs are depreciation, lease, interest expenses, and other capital-related costs defined in § 412.302 that are in use or obligated on or before December 31, 1990.)

In developing the FY 1992 prospective payment rates, there was limited capital data available that could be used to project payments under the capital prospective payment system and develop the budget neutrality adjustment factor. Consequently, we developed a capital acquisition model that relied on Monte Carlo random simulation techniques to project capital costs for 6000 hypothetical hospitals. This model is described in detail in the August 30, 1991 final rule (56 FR 43517-43522). The model will be referred to as the capital acquisition model in the following discussion.

Since publication of the August 31, 1991 final rule, capital data have become available that can be incorporated directly into the determination of budget neutrality. The more recent data include

the June 30, 1992 update of the Hospital-Specific File that provides the data items needed by the PRICER program used by the intermediaries to determine interim capital payments to hospitals, cost reports for cost reporting periods beginning in FY 1989 (PPS-6) (that overlap the base year for determining the hospital-specific rate) and FY 1990 (PPS-7), and data reported by the intermediaries that includes the hospital-specific rate determinations that have been made through June 1992. The June 30, 1992 update to the Provider-Specific File contains data on interim payments under the capital prospective payment system for approximately 60 percent of all hospitals. Generally, the data are for hospitals that became subject to the capital prospective payment system effective with their cost reporting period beginning on or before June 1, 1992.

The available data sources directly supply, or can be used to calculate, the hospital-specific rate. For those hospitals with capital data on the Provider-Specific File, the payment

methodology as well as the estimated FY 1992 hold-harmless amount and new capital ratio for hospitals paid under the hold-harmless payment methodology is also available.

The available data still lack certain items which are required for the determination of budget neutrality. These items are the hospital's new capital costs for each year, its old capital costs for each year, and the obligated capital amounts that will be put in use for patient care services and recognized as old capital each year.

For FY 1993, we are using an integrated model that starts with the available data for existing hospitals and back-fills the missing items with results from the capital acquisition model that was used to develop the FY 1992 payment rates. Since hospitals under alternative payment system waivers are currently excluded from the capital prospective payment system, we excluded these hospitals (hospitals in Maryland and hospitals in the Finger Lakes Area Hospital Corporation in New York) from our model.

We have not modified the parameters of the FY 1992 capital acquisition model; however, we analyzed several capital growth patterns generated by that model to backfill the elements for which actual data are not available. These patterns include the distribution of growth rates in old capital (exclusive of obligated capital), the new capital ratio (which includes obligated capital), and the ratio of obligated capital costs for assets being put in use for patient care to total capital costs. In all cases, the distributions from the model were fitted to the beta distribution. The beta distribution is a two parameter distribution with the range restricted from zero to one. The growth rate for old capital (which is exclusive of obligated capital) must be between zero and one since depreciation and interest on old capital cannot increase. The ratio of new capital to total capital and the ratio of obligated capital to total capital are necessarily between zero and one. Hence, the beta distribution is ideal for these purposes, especially since the two parameters provide a range of shapes.

With regard to the new capital ratio for years after FY 1992, the model fits the change in the ratio from one year to the next to the beta distribution. This is to prevent large swings in the new capital ratio over time. It is possible to have a decrease in the new capital ratio since some new capital may have a short life time compared to old capital. Therefore, we rescaled the range of the changes in the ratios since the beta distribution must have numbers between zero and one.

The model first develops the hospital-specific rate. Where available, this rate is taken from the June 1992 update of the Provider-Specific File. This file contains the actual amounts used by the intermediaries with the PRICER program to compute interim capital prospective payments. If the hospital-specific rate is not available from the Provider-Specific File, the second source is the audit information reported by the intermediaries. If this is not available, the model computes the hospital-specific rate from the hospital's cost reporting period beginning in FY 1989 (PPS-6) as reported on the HCRIS as of June 1992 update. If the hospital-specific rate cannot be determined from the PPS-6 cost reports, the model computes the hospital-specific rate from cost reports beginning in FY 1988 (PPS-5). If still unsuccessful, the model computes the hospital-specific rate from cost reports beginning in FY 1990 (PPS-7). The June 1992 update of HCRIS is used in all cases.

The following table summarizes the data sources for the hospital specific rate.

HOSPITAL SPECIFIC RATE SOURCES BY
NUMBER OF HOSPITALS
[In order of selection priority]

Data source	Number of hospitals
Hospital specific file.....	3,462
Intermediary activity file.....	1,660
PPS-8 cost reports.....	216
PPS-5 cost reports.....	10
PPS-7 cost reports.....	12
Total.....	5,360

We were not able to determine a hospital specific rate for 26 of the 5,360 hospitals in the analysis data base. Consequently, we modeled capital budget neutrality using 5,360 hospitals.

The model also develops the old capital amount for each hospital. If available, the model uses the hold-harmless payment per discharge from the Provider-Specific File. If the actual hold-harmless amount is not available, the model develops an estimate from the hospital's hospital-specific rate. It computes an FY 1990 capital cost per discharge by dividing the 1992 hospital-specific rate by factors used to inflate base year capital cost per discharge to FY 1992 as set forth in the August 30, 1991 final rule (56 FR 43390). The model updates the base year capital per discharge to FY 1992 using a two-year rate of increase (FY 1990 to FY 1992) in old capital that is randomly generated from the beta distribution described

above. This old capital amount for FY 1992 excludes any obligated capital that has been put in use since the base year. Excluding obligated capital from the old capital growth factors produces a more stable growth sequence with lower variance. The development of the hospital's obligated capital costs is described below. Before we update the hospital's old capital costs in a given year, the model adds the obligated capital that is first depreciated in the current year to the old capital cost for that year. As a result, any obligated capital depreciation and interest expense projected by the model is incorporated into the hospital's old capital costs in subsequent years.

The model also develops the new capital ratio for each hospital. If available, the model uses the hospital's new capital ratio from the Provider-Specific File. If the actual new capital ratio is not available, the model generates the ratio from a beta distribution as described above. For purposes of fitting the new capital ratio to the beta distribution, the model treats obligated capital as new capital. The model restricts the new capital ratio to 90 percent in all cases. After fitting the FY 1992 new capital ratio, the year-to-year change in the new capital ratio is fit to the beta distribution. The new capital ratio combined with the old capital amount generates the total capital costs.

Finally, the model develops the obligated capital ratio for obligations first being depreciated in the year under analysis. It generates an obligated capital ratio using a beta distribution fitted to the results of the capital acquisition model (and obligation capital assumptions) as described above. This ratio is an offset to the new capital ratio. Consequently, the obligated capital ratio is restricted to the magnitude of the new capital ratio. The new capital ratio is reduced by the obligated capital ratio.

If a hospital has a hold-harmless payment amount available on the Hospital-Specific File, this amount includes the effect of obligated capital on its FY 1992 old capital costs per discharge. Therefore, the model does not generate any additional FY 1992 obligated capital for these hospitals. We necessarily generated obligated capital amounts for all hospitals for FY 1993 and later.

The model does not recompute the hospital's total capital costs for obligated capital. Instead, obligated capital costs are the product of the obligated capital ratio rate and total capital costs. The hospital's costs for

new capital are the product of the revised new capital ratio times the hospital's total capital costs.

We computed the average total capital cost per discharge from the capital costs that were generated by the model and compared the results to total capital costs per discharge that we had projected independently of the model. We adjusted the component amounts of total capital costs (old capital, obligated capital, and new capital) proportionately so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

As a refinement, we have independently projected total capital costs per discharge for short term care acute care hospitals that do not have Medicare waivers. (The waiver hospitals are in Maryland, and the Finger Lakes area of New York.) We compared the Medicare inpatient capital per case for short-term acute care hospitals subject to the capital prospective payment system to all short term acute care hospitals (including the waiver hospitals for FY 1990. Excluding the waiver hospitals increased the capital cost per case by 0.7 percent. The rate of increase in capital cost per case with, or without the waiver hospitals is practically identical for FY 1988, FY 1989, and FY 1990. Consequently, we can safely assume that waiver status has negligible impact on average rates of change in capital costs.

To summarize, the model integrates actual data with randomly generated amounts developed from the results of the capital acquisition model. For purposes of aggregate capital, we generated at most three numbers for each hospital each year. Only the old capital increase, new capital ratio, and obligated capital ratio are randomly generated.

Once each hospital's capital-related costs are generated, the model projects capital payments. In FY 1992, we randomly generated all payments parameters (for example, the case-mix index and the geographic adjustment factor). In the model, we now use the actual payment parameters that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital. If available, the model uses the payment methodology method indicated in the Provider-Specific File. Otherwise, the model determines the methodology by comparing the hospital's FY 1992 hospital-specific rate to the adjusted Federal rate applicable to the hospital. The model simulates Federal rate

payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the 1991 MEDPAR file using the FY 1993 DRGs and relative weights published in this final rule. The case-mix index is increased 2 percent per year after FY 1991 consistent with the continuing trend (which we expect to continue) in case-mix increase.

Changes in geographic reclassification and corrections in the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year based on the Federal rate after any changes resulting from changes in the DRG classification system and relative weights and in the geographic adjustment factor equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. To determine the budget neutrality adjustment factor needed to make the effect of the DRG and geographic adjustment changes budget neutral on estimated Federal rate payments, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1993 based on its applicable payment methodology. We then compared what aggregate Federal rate payments would be based on the FY 1992 DRG relative weights and FY 1992 geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and the FY 1993 geographic adjustment factor. In making the comparison, we held the FY 1993 Federal rate portion constant and set the other budget neutrality adjustment factor and exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the geographic adjustment factor and the DRG weights, a budget neutrality adjustment factor of .9980 should be applied to the FY 1993 Federal rate.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG weights. Under the

capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low income patients or the large urban add-on.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to project total aggregate payments under the prospective payment system and to compute the budget neutrality adjustment factor that would result in estimated payments under the capital prospective payment system equal to 90 percent of what would have been payable on a reasonable cost basis. This budget neutrality factor is applied to the Federal and hospital-specific rates, but not to the hold-harmless payments.

Additional payments under the exceptions process are financed through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate estimated exceptions payments and the exceptions reduction factor. This exceptions reduction factor ensures that estimated aggregate payments under the capital prospective payment system, including exceptions payments, equal what aggregate payments would be under the capital prospective payment system without an exceptions process. Since changes in the level of payment rates change the level of payments under the exceptions process, the budget neutrality and exceptions adjustments factors must be determined through iteration. Further, these two factors interact with each other so that they must be determined simultaneously. We successfully determined values for these factors so that the exceptions adjustment factor is correct and estimated payments under the capital prospective payment system equal 90 percent of estimated Medicare inpatient capital costs.

In the August 30, 1991 final rule, we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next five years. The table below provides the actual FY 1992 and FY 1993 factors, and the estimated factors that would be applicable through FY 1997. We caution that, except with respect to FY 1992 and FY 1993, these are estimates only and are subject to revisions resulting from continued methodological refinements, more recent data, and any payment policy changes

that may occur. In this regard, we note that in making these projections we have assumed that the DRG/GAF adjustment factor will remain at .9980 because we do not have sufficient information to estimate the change that will occur in the factor in FY 1994. In this final rule, we are adding a new requirement for individual hospital wage index reclassification that we estimate will result in 75 percent of the individual

hospitals that qualified for reclassification in FY 1993 no longer qualifying in FY 1994. Although we expect that the fewer reclassification will result in a positive budget neutrality adjustment, we cannot estimate the magnitude of the adjustment at this time for two reasons. First, we do not know how many of the hospitals that no longer qualify for individual wage reclassification will qualify for a group

reclassification for purposes of both the wage index and the standardized amount. Second, we do not know the effect that fewer reclassifications, coupled with the new wage data and revised labor market areas, will have on the hospital wage index and geographic adjustment factor.

The projections are as follows:

Fiscal year	Increase in cost per discharge ¹	Update factor	Exceptions reduction factor	Budget Neutrality factor	Federal rate (after outlier reduction)
1992.....	6.43	N/A	0.9813	0.9602	415.59
1993.....	7.43	6.07	.9756	.9162	417.29 ²
1994.....	8.48	5.19	.9379	.9367	431.43
1995.....	8.44	5.28	.9000	.9597	446.55
1996.....	8.47	6.93	.9000	N/A	497.55
1997.....	8.51	7.95	.9000	N/A	537.11

¹ NOTE: Adjusted for estimated 2.0 percent annual increase in case-mix index.

² NOTE: Includes the DRG/GAF adjustment factor of 0.9980 and the change in the outlier adjustment from 0.9497 in FY 1992 to 0.9495 in FY 1993. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Comment: A few commenters expressed concern about the sensitivity of estimating per case capital payment rates to the assumptions used in the capital projection model. These commenters claim that there are clear differences between the model and actual data for factors such as the amount of obligated capital, and number of hold-harmless hospitals, exceptions, and outlier payments.

Response: It is important to draw a distinction between the model, and the assumptions used by the model. The model must necessarily be sensitive to changes in assumptions. As information becomes available, we refine our assumptions, and the model responds appropriately. Since we are setting budget neutrality prospectively, we must make assumptions about future changes, and about factors which have not been completely determined, or which have not yet been reported to us.

As stated in the June 4, 1992 proposed rule and repeated in the above description of the model, we modified the FY 1992 capital acquisition model to incorporate actual data to the maximum extent possible. As more data become available, we will incorporate this additional data. Until audits and hospital-specific rate determinations and obligated capital have been completed, it is not possible to improve our estimates of obligated capital, exceptions and outlier payments and the number of hold-harmless hospitals.

We have confidence in our model. It is the only model that is constrained to historic and projected capital levels, and reacts in an appropriate manner to all the provisions and factors in the capital

prospective payment system. We are monitoring emerging experience, and we will continue to modify our assumptions in conformance with the experience. We will also continue to incorporate actual data to the maximum extent possible.

Comment: Several commenters requested that HCFA increase efforts to assure that funds set aside for exceptions and outlier payments are paid to hospitals.

Response: As part of the rate-setting process, we estimate anticipated exceptions payments and reduce the Federal rate and hospital-specific rate by the estimated value of the exceptions payments. (In addition, the Federal rate is reduced by the estimated value of outlier payments.) There are, however, no funds "set aside" for these payments. As with the budget neutrality adjustment, the estimates are based on the best data available at the time the rates are established and actual payments may be more or less than the estimated amounts. Although capital outlier payments are lower than we estimated when the FY 1992 capital rates were established, we estimate total capital payments will exceed 90 percent of what would have been payable on a reasonable cost basis. Based on our current estimates, capital payments will equal 92.85 percent of reasonable costs. Taking the phase-in of the capital prospective payment system into account, this represents excessive capital payments of approximately \$90 million. We do not make retroactive adjustments for any of our estimates. Instead, we are refining our FY 1993 estimates for outliers and exceptions payments and the budget neutrality

adjustment factor on the basis of the more recent data. We will continue to refine our estimates for future rate-setting as more recent data become available.

Commenter: A commenter requested that we separately report the DRG recalibration and geographic adjustment factor budget neutrality factors.

Response: We determine a joint budget neutrality adjustment factor because of potential interactive effects between the DRG changes and the geographic adjustment factor. However, we have computed separate factors to determine the magnitude of each on the combined adjustment factor. We first determined that to achieve budget neutrality for the changes in the geographic adjustment factor using the FY 1992 DRG weights the budget neutrality adjustment factor be .9984. We then compared what aggregate Federal rate payments would be based on the FY 1992 DRG relative weights and the FY 1993 geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and geographic adjustment factor with the 0.9984 adjustment factor applied in both cases. In making the comparison, we held the FY 1993 Federal rate portion constant and set the other budget neutrality adjustment factor and exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the DRG weights, a further budget neutrality adjustment factor of 0.9996 in addition to the 0.9984 should be applied to the FY 1993 Federal rate. This yields a total adjustment of 0.9980.

Appendix C: Recommendation of Update Factors for Rates of Payment for Hospital Inpatient Operating Costs

I. Background

Several provisions of the Social Security Act (the Act) address the setting of update factors for services furnished in FY 1993 by hospitals subject to the prospective payment system and hospitals excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(VIII) of the Act, as enacted by Public Law 101-508, sets the FY 1993 applicable percentage increases in the operating cost standardized amounts for prospective payment hospitals equal to the hospital market basket percentage increase minus 1.55 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.55 percentage points for hospitals located in rural areas. Section 1886(b)(3)(B)(ii) of the Act governs the target rate-of-increase limits for hospitals excluded from the prospective payment system and the hospital-specific rate applicable to sole community hospitals. In accordance with section 1886(d)(3)(A) of the Act, we are updating the average standardized amounts, the hospital-specific rates and the target rate-of-increase limits for hospitals excluded from the prospective payment system as provided for in section 1886(b)(3)(B) of the Act, as set forth above.

Sections 1886(e)(2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1 of each year an update factor for the next fiscal year that takes into account changes in the market basket index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. As required by section 1886(e)(5) of the Act, we published the recommended FY 1993 update factors as appendix D of the proposed rule (57 FR 23835).

II. Secretary's Final Recommendations for Updating the Prospective Payment System for Operating Costs Standardized Amounts

We received several public comments concerning our proposed recommendation. After consideration of the recommendations presented by the commenters, we have decided that our final recommendation will be the same as our proposed recommendation. That is, we are recommending that the operating standardized amounts be increased by an amount equal to the market basket percentage minus 1.55 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.55 percentage points for hospitals in rural areas. Based on the currently forecasted market basket increase of 4.1 percent, the recommended updates are 2.55 percent for hospitals in urban areas and 3.55 percent for hospitals in rural areas.

We are recommending that the hospital-specific rate applicable to sole community hospitals be updated by an amount equal to the market basket percentage increase minus 1.55 percentage points, or 2.55 percent. With the exception of the higher update for the rural standardized amount, we believe that the considerations used to develop our update recommendation for the standardized amounts are also applicable to the hospital-specific rate for sole community hospitals. Our recommendation for a higher update to the rural standardized amount is intended to reduce the differential between the standardized amounts for other urban and rural hospitals, which is not an applicable consideration for hospital-specific rates.

In recommending these increases, we have followed section 1886(e)(4) of the Act, which indicates that we should take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC.

We are recommending an update that is consistent with the Administration's budget proposal that all hospitals receive an update in their payments for FY 1993 based on the current market basket forecast with the adjustments set forth in Public Law 101-508. The latest forecast shows that the FY 1993 rate-of-increase in the hospital market basket will be 4.1 percent.

Our recommendation is supported by our analyses, which measure changes in hospital productivity, scientific and technological advances, practice pattern

changes, and changes in case mix. We are recommending that the standardized amounts applicable to urban hospitals and the hospital-specific rates applicable to sole community hospitals be updated in FY 1993 by an amount equal to the market basket percentage increase minus 1.55 percentage points. However, we believe a differential update for the standardized amount applicable to rural hospitals is appropriate in order to phase out the differential between the rural and other urban standardized amounts. Therefore, we are recommending that the rural standardized amount be updated by an additional 1.0 percentage point, for a total update of 3.55 percent (that is, market basket minus 0.55 percentage points).

Comment: Several commenters believe that the hospital market basket does not properly reflect increases in costs faced by hospitals.

Response: The process used to develop the hospital market basket was specifically designed to reflect price increases that are appropriate for efficiently managed hospitals. The methodology and rationale are described in detail in the September 4, 1990 final rule (55 FR 36044). Since we provided a thorough response to comments on the hospital market basket in the September 4, 1990 final rule and did not propose any changes in the June 4, 1992 proposed rule, we are not responding to specific comments on the hospital market basket in this final rule. We believe that the market basket continues to recognize appropriate input price increases for efficiently managed hospitals.

Comment: A commenter believes that we should adjust the hospital market basket rate of increase to account for the cost-increasing effects of new technologies.

Response: In the framework used to support our update recommendations, we adjust the market basket rate of increase to account for the costs of new technology. This factor is encompassed as part of the update framework, rather than the market basket itself. In the framework used to support our FY 1993 update recommendation, we include a +0.3 to +0.5 percent increase for science and technology.

Comment: A few commenters advocate an update factor equal to the market basket rate of increase, rather than those updates set by the statute.

Response: Section 1886(b)(3)(B)(i)(VIII) of the Act requires that the update factors be set at the market basket rate of increase minus 0.55 percentage points for rural

hospitals, and the market basket percentage rate of increase minus 1.55 percentage points for urban hospitals. We are required by the statute to implement these update factors.

Comment: ProPAC disagreed with our recommendation that the hospital-specific rate applicable to sole community hospitals be updated by an amount equal to the urban update, or the market basket percentage increase minus 1.55 percentage points. The Commission believed that the update applied to the hospital-specific rate should be the rural update factor, that is, the market basket percentage increase minus 0.55 percentage points. The Commission believed that our recommendation is contrary to Congress' intention to provide financial relief to these hospitals.

Response: We responded to a similar comment in the FY 1992 final rule (56 FR 43354). We continue to believe that the differential update for the rural standardized amounts is intended to phase out the lower rural payment rates. Sole community hospitals are assured payment at the greater of the Federal rate or the hospital-specific rate. Hospitals that are paid at the hospital-specific rate are already benefitting from payments higher than other rural hospitals receive. We do not believe that these high cost rural hospitals that are already receiving higher payments should also benefit from a payment change intended for rural hospitals paid at a lower Federal rate. Rather, we are recommending that the hospital-specific rate applicable to sole community hospitals be updated by the market basket percentage rate of increase minus 1.55 percentage points, or 2.55 percent.

Comment: ProPAC disagreed with the framework we used to develop our recommended updates for the standardized amounts. In particular, they objected to the use of a practice patterns adjustment that was based on a study done in the early years of the prospective payment system. ProPAC believed that our adjustment for science and technology was too low. Finally, they believed that we should consider within-DRG severity and should not adjust for the effects of DRG reclassification and recalibration in

setting the CMI component of our update framework.

Response: Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend for each fiscal year update factors that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Since FY 1986, we have used an analytical framework to support the update recommendation. In appendix D to the FY 1992 final rule (56 FR 43354), we noted that we were in the process of refining that analytical framework. Our intent is to develop an expanded conceptual framework and appropriate measures for each component, that would be used to support our update recommendations. In appendix C to the FY 1992 proposed rule (56 FR 25321), we invited public comment on the appropriate factors and measures that should be taken into consideration in determining an appropriate update.

Under the current framework used to calculate our recommended updates, we look at the hospital market basket rate of increase and make adjustments to take into account both policy adjustment factors and changes in case mix, as well as corrections to forecast errors in previous estimates of the market basket rate of increase. The policy adjustment factors consist of measures of change in hospital productivity, quality-enhancing scientific and technological advances, and changes in practice patterns. The productivity measure consists of a normative standard, based partly on economy-wide increases in productivity, that accounts for the effect on prices that productivity increases would have in a competitive industry. The science and technology factor adjusts for the diffusion of new technology that is also quality-enhancing. Finally, the practice pattern adjustment is designed to ensure that the government shares in any improvements in practice patterns that make the provision of care less costly, while maintaining quality of care.

The adjustment in the current framework consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change which we believe is due to

increased severity of illness rather than coding improvements, and an adjustment for the effect of reclassification and recalibration changes, to reflect what the total case-mix index change would have been if a new GROUPE and relative weights had not been instituted. The adjustment for the reclassification effect may be either a positive or a negative adjustment and represents a correction to the observed case-mix change. It is determined by comparing the average case weight for the actual cases in a given year based on the DRG relative weights for that year with the average case weight for the same cases based on the DRG relative weights for the previous year. Since the actual cases for the fiscal year are used on both sides of the comparison, the difference represents the change in the case-mix index and, therefore, reflects aggregate payments attributable to the new GROUPE and relative weights.

Presented below is a modified analytical framework for the update recommendation. We are considering using the revised framework to develop our recommendation for updating the prospective payment system standardized amounts beginning in FY 1994. We are presenting it in order to solicit comments and suggestions for improvement. So that we may take any comments into account prior to development of the proposed update recommendation for FY 1994, any comments should be sent to the following address by December 31, 1992: Update Framework, Division of Hospital Payment Policy, 1-H-1 East Low Rise, 6325 Security Blvd., Baltimore, Md. 21207.

III. Modifications to the Update Framework

A. General

The modified framework we are presenting is similar to our current framework, except in the definition of the policy adjustment factors. We have continued to use our current framework with the FY 1993 update recommendation; however, we are considering using the modified framework beginning in FY 1994. Our current framework and the modified framework are both based on the following formula:

$$\begin{array}{ccccccc}
 \text{Nominal cost} & & \text{Real Outputs} & & \text{Real caseweights} & & \text{Real noncapital} \\
 \text{Discharge} & = & \text{Real caseweights} & \times & \text{Discharges} & \times & \text{inputs} \\
 \text{(A)} & & \text{(B)} & & \text{(C)} & & \text{(D)} \\
 & & & & & & \text{Real outputs} \\
 & & & & & & \text{Nominal costs} \\
 & & & & & & \text{Real noncapital} \\
 & & & & & & \text{inputs} \\
 & & & & & & \text{(E)}
 \end{array}$$

In the formula, (A) represents the average cost per discharge, (B) represents our measure of case-mix constant intensity, (C) represents the case-mix index, (D) represents the inverse of service productivity, and (E) represents the hospital market basket. The main differences between the current and the modified frameworks lie in the data used to develop the productivity standard, and in the definition of intensity. The current framework divides intensity into a practice patterns adjustment and an adjustment for science and technology, while the modified framework uses a direct measure of intensity.

Under the modified framework, we would have two policy adjustment

factors: Productivity and intensity. The first would reflect a forward-looking adjustment for expected changes in services level productivity in hospitals. This measure would reflect the efficiency with which individual services (for example, laboratory tests, diagnostic procedures) are produced. The intensity component would reflect how these services are utilized to produce the final output—the discharge. This component would account for the intensity of services per discharge and would include changes in the use of quality-enhancing services including new technologies and expected modification of practice patterns to remove cost-ineffective services. It would also be used to account for

changing resource requirements due to variations in within-DRG severity of illness. The intensity component would replace our previous separate components for science and technology and practice patterns, and would take into account within-DRG severity changes. Throughout the following discussion, we compare our modified framework to the existing ProPAC framework.

The following is a summary of the FY 1993 update ranges supported by our modified analyses compared to our existing framework and ProPAC's framework.

TABLE 1.—Comparison of FY 1993 UPDATE RECOMMENDATIONS

	Current HHS	Modified HHS	ProPAC
Market Basket.....	MB	MB	MB
Difference Between HCFA & ProPAC Market Baskets.....			+0.2
Subtotal.....	MB	MB	MB +0.2
Policy Adjustment Factors:			
Productivity.....	-1.0	-0.8 to -1.0	-1.0
Intensity.....		+1.0 to +1.1	
Science and Technology.....	+0.3 to +0.5		+1.0
Practice Patterns.....	-1.8 to 0		(¹)
Real Within-DRG Change.....			(²)
OSHA Modification to 29 CFR Part 1910.1030.....	+0.14	(³)	(³)
Subtotal.....	-2.36 to -0.36	+0.0 to +0.30	+0.0
Case-Mix Adjustment Factors:			
Observed Case-Mix Change.....	-2.5	-2.5	-2.5
Real Across-DRG Change.....	+1.0 to +1.3	+1.0 to +1.3	+1.5
Real Within-DRG Change.....	(⁴)	(⁵)	+0.3
Effect of 1990.....			
Reclassification and Recalibration.....	-1.0	-1.0	
Subtotal.....	-2.5 to -2.2	-2.5 to -2.2	-0.7
Forecast Error Correction.....	-0.9	-0.9	-0.8
Total Recommended Update.....	MB -5.76 to MB -3.46	MB -3.40 to MB -2.80	MB -1.3

¹ Included in ProPAC's Productivity Measure.

² Included in ProPAC's Case Mix Adjustment.

³ Included in HHS' Productivity Adjustment and ProPAC's Science and Technology Adjustment.

⁴ Included in HHS' Practice Patterns and Science and Technology components.

⁵ Included in HHS' Intensity Factor.

There are two basic reasons for having a modified framework that recognizes two levels of production in hospitals. First, the modified framework allows us to refine the concepts of productivity, efficiency, and cost-effectiveness as they apply to the hospital setting, because we envision employing and developing a wider range of relevant data series to use in formulating our annual recommendations. For example, we would be able to evaluate our productivity standard with respect to unit productivity and real output data from both the hospital industry and the general economy. Second, this framework recognizes that while hospitals are largely responsible for the

efficiency with which individual services are produced, the cost-effective use of these services in providing care during the hospital stay is jointly determined by the hospital and its medical staff. Therefore, by distinguishing the two levels of production, we can in the future improve the consistency between the objectives embodied in the cost-effective practice component of the prospective payment system update recommendation and our Volume Performance Standard (VPS) recommendation for the physician fee schedule.

In employing this framework, we would recognize that the potential for changes in service productivity is related to the overall output of services.

Economy-wide, unit productivity tends to increase most rapidly during periods of output growth, and grow more slowly or decrease during periods in which output declines. Thus, in formulating our recommendation for the productivity component of the update factor, we would consider expected growth in total hospital services including admissions, case mix, technology and cost-effective practice. Our expectations for output, which are partly determined by our policy target for the intensity component (which includes many of these factors), will therefore influence our service productivity recommendation. In the discussion below, we first describe how our recommendation for the intensity component would be determined

followed by the development of our productivity recommendation.

B. Intensity Component

We would base our intensity standard on the combined effect of three separate factors: changes in the use of quality-enhancing new technology, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For 1993, we would have recommended that this factor be 1.0 percent to 1.1 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level for quality-enhancing technology changes. Typically, a specific new technology increases costs in some uses and decreases costs in other uses.

Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies. In the early years of the prospective payment system, ProPAC conducted several studies of new technology costs and concluded that they were fairly low. Those studies focused primarily on the acquisition costs of the new technologies but also looked at diffusion of new technologies and operating costs. Project Hope, under contract with ProPAC annually estimates the incremental operating costs of specific cost-increasing technologies. However, we know of no definitive studies that establish an appropriate level or range for this factor. ProPAC's recommended adjustment is for the cost-increasing effect of new technologies only, and for FY 1993 assumes the range of estimated costs for these technologies at 0.9 to 1.0 percent, with a best estimate of 1.0 percent. ProPAC includes the cost-decreasing effect on new technology in its productivity adjustment factor.

The quality-enhancing technology component is intended to recognize the use of services that increase cost, but whose value in terms of enhanced health status is commensurate with these costs. Such services may result from technological change, or in some cases, increased use of existing technologies. The latter recognizes that as cost and medical effectiveness studies become available, some increased use of existing, as well as new, services may be warranted.

The component for reduction of cost-ineffective practices recognizes that some improvements in practice patterns

could be made so that the intensity of services provided is more consistent with the efficient use of limited resources. That is, improvements could be made so that the number of services provided during an inpatient stay, and their complexity, produce an improvement in health status that is consistent with the cost of care. This component of our update recommendation is intended to encourage both hospitals and physicians to consider more carefully the cost effectiveness of medical care.

In our current framework, the component for real within-DRG change is implicitly recognized in the new science and technology factor and in the practice pattern components. In our proposed framework, it would be recognized in the intensity component.

Since 1985, intensity of services per inpatient admission has increased, even after adjusting for the growth in real case mix each year. These increases, which are similar to pre-prospective payment system increases, followed intensity decreases in both 1984 and 1985. ProPAC, following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, has estimated that case-mix constant intensity per admission increased at an average of 1.5 percent annually from 1985-1990. We have developed Medicare-specific intensity measures for inpatient services based on 1985-1991 MEDPAR billing data. Consistent with ProPAC, case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Medical Consumer Price Index hospital component and changes in real case mix. Past studies of case-mix change by the RAND Corporation indicate that the change in real case mix ranges from 1.0 percent to one-half of total case-mix change. If we assume that real case-mix change is one-half of total case-mix change, we estimate case-mix constant intensity to have grown by an average of 2.0 percent each year during the 1985-1991 period, a cumulative increase of 12.8 percent. If we assume that real case mix has been growing at 1.0 percent annually, case-mix constant intensity has grown by an average of 2.3 percent annually, for a cumulative increase of 14.3 percent.

We believe that the estimated intensity increases have been due to a combination of changes in science and technology, within-DRG severity, and cost-ineffective practice. Currently, however, there are no conclusive studies that quantify either the net impact of

new science and technology on operating costs or on within-DRG complexity changes. Thus, we cannot estimate precisely what portion of the overall intensity increase was due to a combination of quality-enhancing technology and within-DRG complexity, and what portion was due to cost-ineffective practice. We are instead assuming that one-half of the 2.0 to 2.3 percent annual increase was due to a combination of quality-enhancing services and within-DRG complexity. Therefore, based on these trends, our proposed recommendation would have included a 1.0 percent to 1.1 percent positive adjustment to the update to allow for a cost-effective increase in the intensity of services in FY 1993.

While we would continue in the future to examine historical trends in formulating the intensity component, our intent is that it will become a forward-looking factor that incorporates expanding knowledge from medical effectiveness studies. Our eventual objective is to identify a set of efficient or "best practice" hospitals to serve as a basis for this adjustment. In addition, in recognition of the joint roles of hospitals and their medical staff in furnishing inpatient care, we intend to examine methods for calibrating our hospital update recommendation with our annual volume performance standard (VPS) recommendation for the Medicare physician fee schedule. In evaluating methods for calibrating our two recommendations, one potential area of study will be to examine those services billed simultaneously by physicians under Part B and by hospitals under Part A.

C. Productivity Component

Service level productivity is defined as the ratio of total service output to full time equivalent employees (FTEs). It is also called service productivity since these services become inputs for the production of a hospital discharge. While we recognize that productivity is multifactor in nature (that is, a function of labor, non-labor material, and capital inputs), we propose to use a labor productivity measure in the modified framework since the current update framework applies to operating payment. To recognize that we are apportioning the short run output changes to the labor input, we propose to weight our productivity measure for operating costs by the appropriate share of labor input to total operating input to determine the expected effect on cost per case. In our proposed framework for updating capital payments (see Appendix D), we discuss unifying the

capital and operating frameworks by considering expanded productivity concepts with regard to the capital input.

ProPAC believes hospitals should be given an incentive to improve productivity. In its recommended update framework, ProPAC measures productivity as the ratio of hospital admissions (adjusted for case mix and outpatient services) per FTE employee (adjusted for changes in skill mix). This year, ProPAC assumes a per case productivity gain of at least 2.0 percent and recommends a -1.0 percentage point adjustment in determining the update on the basis that any productivity gains should be shared equally by Medicare and hospitals. However, ProPAC's measurement is based on per-case productivity rather than service productivity, so ProPAC's productivity measurement includes the effect of changes in practice patterns and cost-decreasing new technology. As explained earlier, the productivity measurement in the proposed framework embraces only changes in service productivity. We would make an adjustment to reflect average expected gains in service productivity; a hospital would retain in full any service growth at 3.8 percent annually, implying a ratio of service productivity gains it achieves above this level.

Our proposed recommendation for the service productivity component is based on historical trends in productivity and total output for the hospital industry and the general economy, as well as projected levels of future hospital service output. ProPAC has also estimated cumulative service productivity growth to be 4.6 percent from 1985-1989, or 1.1 percent annually. At the same time, it estimates total service growth at 3.8 percent annually, implying a ratio of service productivity growth to output growth of approximately 0.3 percent. Our MEDPAR analysis implies total Medicare service output (charges per admission, adjusted for CPI change) increased 22.1 percent from 1985-1991, or 3.4 percent annually. It is not possible at this time to develop a productivity measure specific to Medicare patients. We also examined output (gross domestic product) and productivity (output per hour) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 percent to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with an 0.3 to 0.35 percent change in output per hour).

Under the modified framework, the recommended update would be based in

part on expected productivity, that is, projected service output during the year multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket. This method would estimate an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. In doing so, the recommendation allows for unit productivity to be smaller than the historical averages in years in which output growth is relatively low, and higher in years in which output growth is larger than the historical trend. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected "real" case-mix growth and expected quality-enhancing intensity growth, net of expected decline in intensity due to reduction of cost ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply product of the expected change in intensity (1.0 to 1.1 percent), projected admissions change (2.3 percent for 1993) and projected "real" case-mix growth (1 percent for 1993), or 4.3 to 4.5 percent. The share of direct labor services in the hospital market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent. Multiplying the expected change in total hospital service output by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage provides our productivity standard of 0.8 percent to 1.0 percent.

In the December 6, 1991 *Federal Register* (56 FR 64004), the Occupational Safety and Health Administration (OSHA) published a final rule (29 CFR 1910.1030) implementing regulations requiring organizations to use a variety of means to reduce the risk of employees contracting blood borne pathogens, including hepatitis B virus and human immunodeficiency virus. In that rule, OSHA estimates the impact on hospitals will be additional costs of 0.14 percent of total revenues. Under the

existing framework, we are providing for a positive adjustment of 0.14 percent to account for these additional costs. This is a one-time adjustment, since the 0.14 percent will be built into the rates for subsequent years. Under the modified framework, we would have included the adjustment in the productivity factor. ProPAC has not recommended any explicit adjustment for the effects of these regulations but has implicitly included the costs in its adjustment for new science and technology.

D. Case-Mix Adjustments

Our modified update framework continues to take into account changes in case mix, net of changes attributable to improved coding practices and DRG reclassification and recalibration. We found that the observed increase in case mix was 2.5 percent during FY 1991. We estimate real case-mix increase at 1.0 percent to 1.3 percent. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but that do not reflect greater resource requirements. This estimate is supported by past studies of case-mix change by the RAND Corporation. In addition, we estimate that DRG reclassification and recalibration in FY 1991 resulted in a 1.0 percent increase in the case-mix index. This estimate results from classifying cases using the FY 1991 and FY 1990 GROUPERS using actual FY 1991 cases received by HCFA as of December 31, 1991. Any resulting change in the case-mix index based on the FY 1991 GROUPER as compared to the FY 1990 GROUPER must be the result of reclassification and recalibration effects. The resulting adjustment to account for changes in case mix during FY 1991, the most recent year for which data are available, is -2.5 to -2.2 percent (the sum of -2.5, +1.0 to +1.3, and -1.0). The -2.5 and 1.8 percent figures used in the ProPAC framework for their FY 1993 update recommendation represent ProPAC's projection for observed case-mix change and real case-mix change, including within-DRG case complexity change, during FY 1992. ProPAC's observed case-mix change is estimated, whereas our observed case-mix change is based on FY 1991 bills received through June 30, 1992.

E. Forecast Error Correction

The FY 1991 estimated market basket percentage increase used to update the payment rates was 5.2 percent. Our most

recent data indicate the actual FY 1991 increase was 4.3 percent, reflecting that the increase in wages was lower than projected. The resulting forecast error in the projected FY 1991 market basket rate of increase forecast was -0.9 percentage points. Our policy has been to make a forecast error correction if our estimate is off by 0.25 percentage points or more. We would continue to make corrections for forecast errors under the modified framework, and would therefore include a forecast error

adjustment of -0.9 percentage points in setting PPS rates for FY 1993. ProPac's FY 1993 recommendation includes a forecast error adjustment of -0.8 percentage points, based on an earlier estimate of the FY 1991 market basket rate of increase.

F. Comparison of Increases in Expected Costs and Payments

In addition to comparing our modified update framework with the existing framework and ProPac's recommended

framework, we examined the expected increase in costs implied by the framework from FY 1985 through FY 1991. Applying the analysis of the modified framework, the costs for efficiently operated hospitals would have been expected to increase 41.2 percent during that time, assuming the "real" increase in the case-mix index (CMI) growth was one-half of the total CMI growth for each fiscal year:

CUMULATIVE PERCENTAGE CHANGE IN EXPECTED COST PER CASE INCREASES, ASSUMING ONE-HALF OF ACTUAL ANNUAL CMI GROWTH IS REAL

Fiscal year	Actual market basket	Productivity	Real CMI growth	Allowable intensity	Total
1986	3.9	-0.8	1.7	1.7	6.6
1987	3.7	-0.8	1.3	2.4	6.6
1988	4.7	-0.8	1.1	1.4	6.5
1989	5.4	-0.8	1.3	0.3	6.3
1990	4.5	-0.8	1.1	0.2	5.0
1991	4.3	-0.8	1.0	0.1	4.6
Cumulative Change (Compounded)					41.2

Note: Actual market basket figures include correction for any forecast errors. The productivity amount is based on average annual increases in real Medicare output of 3.4 percent from FY 1985 through FY 1991. Real CMI growth for FY 1988 is determined as half of the CMI growth remaining after

allowing for the 1.22 percent growth determined to be caused by administrative factors (and for which the DRG weights were reduced in FY 1990). The FY 1990 and FY 1991 CMI growth is adjusted for the DRG weight change implemented in FY 1990. The components of change must be multiplied together to obtain the total percentage change.

If "real" CMI growth is assumed to be 1.0 percent annually, the cumulative percentage change in expected cost per case would be 40.3 percent.

We also determined the increase in prospective payments from FY 1985 through FY 1991:

ACTUAL PERCENTAGE INCREASE IN PPS PAYMENTS PER CASE, FY 1985-FY 1991

Fiscal year	Average published update	PPS CMI growth	Residual payment change	Actual increase
1986	0.5	3.4	-0.7	3.2
1987	1.2	2.5	1.5	5.3
1988	1.5	3.3	1.3	6.2
1989	3.3	2.7	-0.1	6.0
1990	5.8	1.0	-1.2	5.5
1991	3.4	2.7	-1.5	4.6
Cumulative Change (Compounded)				35.0

Note: Payment growth rates are calculated from Medicare cost report data. Residual payment growth is due to factors such as increased IME and DSH factors, and legislative changes (such as increases in the DSH adjustment formula). CMI growth rates are calculated by HCFA's Office of the Actuary.

Payments in FY 1985 were more than adequate for the efficient and cost-effective delivery of quality health care to beneficiaries, as shown by the prospective payment system margins exhibited by hospitals in that year. The average prospective payment system FY 1985 operating margin was 14.5 percent. In fact, when setting the update to the standardized amounts for FY 1986, we stated in our September 3, 1985 final rule (50 FR 35708) that a negative update was justified due to the overstatement of the base year costs used to determine the FY 1984 and FY 1985 standardized amounts, but that we believed that such a negative update would be disruptive

and cause unintended consequences that could compromise the quality of care provided to Medicare beneficiaries. Instead, we anticipated that payments would increase more slowly than expected cost increases, in order to gradually adjust the standardized amounts to their appropriate levels. ProPac agreed that the FY 1985 standardized amounts were set at too high a level, and also agreed that a precipitous adjustment would not be appropriate. The Commission, in its April 1, 1987 report to the Secretary, recommended that an average 5.4 percent reduction to the standardized amounts be made over a 3-year period

to reflect the inappropriate levels of base year costs reflected in the original standardized amounts.

Although the expected increase in the cost of providing cost-effective and quality care was between 40.3 and 41.2 percent, we believe that the increase in payments of 35.0 percent was more than adequate to cover the costs of efficiently operated hospitals, given the high margins in FY 1985 and the overstated FY 1985 standardized amounts. We will continue to examine the relationship between payment increases and expected cost increases in order to monitor the adequacy of Medicare

payments for inpatient hospital operating costs.

IV. Secretary's Final Recommendations for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

We are updating the rate of increase limits in accordance with section 1886(b)(3)(B)(ii) of the Act, which establishes a uniform update factor for excluded hospitals and units at the market basket rate of increase. (The market basket for excluded hospitals is currently estimated at 4.2 percent.) However, as we proposed in the June 4, 1992 final rule, we are recommending an average update for excluded hospitals that would result in total payments comparable to those resulting from an update equal to the market basket rate of increase. More specifically, we recommend that excluded hospitals and units whose base year began during the period FY 1983 through FY 1987 receive a higher update than hospitals whose base year began in FY 1982 or after FY 1987.

We recommend that excluded hospitals and units with an FY 1982 base year or a base year that began after FY 1987 receive an update equal to the market basket percentage increase minus 1.6 percent. The 1.6 percentage point adjustment is to account for the forecast error in the FY 1990 market basket rate of increase of 0.9 percentage points, plus the forecast error in the FY 1991 market basket rate of increase of 0.7 percentage points.

In addition, we recommend, and ProPAC agrees, that a higher update for hospitals and units that were excluded in the early years of the prospective payment system is appropriate. This is because the updates applied to excluded hospitals in FYs 1986, 1987, and 1988 were considerably less than the market basket rate of increase and were based on some considerations appropriate only to hospitals subject to the prospective payment system. We agree with ProPAC as to the basis for the cumulative positive allowance adjustment, which is consistent with our calculation of the compounded difference between the updates received and the market basket rate of increase, as described in the June 3, 1991 proposed rule (56 FR 25322).

Base year began in FY	FYs subject to ceiling	Compounded adjustment
1982.....	1983-1988	-0.5
1983.....	1984-1988	2.1
1984.....	1985-1988	4.2
1985.....	1986-1988	6.9
1986.....	1987-1988	4.4

Base year began in FY	FYs subject to ceiling	Compounded adjustment
1987.....	1988	2.1

We recommend, and ProPAC agrees, that any additional update allowance be made in a budget neutral fashion. The lower updates are only part of the explanation for why hospitals with early base years are more financially vulnerable than hospitals that more recently became subject to the rate-of-increase limits. Another consideration is that these hospitals have been subject to the limits for a longer period of time and, in the case of those hospitals with a FY 1982 or FY 1983 base year, have a target amount that was established before the prospective payment system was implemented. For these reasons, we are recommending a 2.6 percent update (4.2 percent market basket for excluded hospitals minus 1.6 percent) for hospitals with an FY 1982 base year, even though a lower update would appear warranted based on the cumulative difference between the market basket increase and the update factors.

We have used the results of the analysis of the cumulative difference between the market basket rate-of-increases and the update factors to determine differential additional adjustments that will result in program outlays that approximate the outlays that would result if a 4.2 percent update were applied in FY 1993. Our recommended update factor is 2.6 percent for all excluded hospitals and units, plus an additional update for hospitals and units with a base year beginning during the period FY 1983 through FY 1987. The recommended updates are as follows:

Base year began in FY	General update	HCFA recommended additional adjustment	HCFA recommended FY 1993 update
1982.....	2.6		2.6
1983.....	2.6	1.8	4.4
1984.....	2.6	3.8	6.4
1985.....	2.6	6.0	8.6
1986.....	2.6	3.9	6.5
1987.....	2.6	1.8	4.4
1988 and later..	2.6		2.6

Comment: A commenter stated the update for excluded units and hospitals should equal the entire excluded hospital market basket rate of increase.

Response: Section 1886(b)(3)(B)(ii) of the Act sets the FY 1993 target rate-of-increase limits for hospitals excluded from the prospective payment system at

the market basket rate of increase for excluded facilities. Our recommendation is to provide an average update equal to the market basket rate of increase while providing differential updates to those facilities with base years that began in FY 1983 through FY 1987. The update that will be implemented, however, is that set in law.

Comment: Several commenters objected to our use of the FY 1990 and FY 1991 TEFR market basket forecast error to finance the differential updates for excluded hospitals and units with a base year beginning between FY 1983 and FY 1987. The commenters believe that it is inappropriate to lower the update amounts for excluded facilities with base years that began in FY 1982 or after FY 1987 in order to finance the differential updates for other facilities. The commenters indicated that the differential updates should be financed with additional funds. Another commenter supported our recommendation.

Response: We believe that it is appropriate to remove market basket forecast errors from future updates. These errors in estimation of the increase in payments are permanently built into the excluded facilities' target amounts. As a result, the target amounts do not properly reflect the updated cost per discharge necessary for efficiently operated hospitals to maintain quality care for Medicare beneficiaries. We are in no way penalizing any excluded facility, regardless of its base year, but are ensuring that the appropriate market basket rates of increase are reflected in the target amounts.

Our recommendation for updates for all excluded facilities in this final rule is based on a 2.6 percent update for FY 1993 (consisting of an estimated excluded hospital market basket rate of increase of 4.2 percentage points, and forecast error adjustments of -0.9 percentage points for FY 1990 and -0.7 percentage points for FY 1991). We are recommending that the 1.6 percentage points, consisting of the FY 1990 and FY 1991 forecast errors, be used to fund the higher updates for those hospitals with base years beginning in Federal FYs 1983 through 1987, which were subject to the prospective payment system updates for those years. Additionally, some exceptions payments to these hospitals will no longer be necessary as a result of the higher updates, and we have taken our estimation of this effect into consideration in developing the differential updates.

We believe that the differential update should be budget neutral because it is not clear that an aggregate

increase in payments in excess of the market basket rate of increase is warranted, or that any increase in payments is more appropriately distributed to excluded hospitals through a differential update factor rather than through a more targeted approach directed toward groups of hospitals whose costs are systematically above the rate-of-increase limit. We believe any increase in aggregate payments to excluded hospitals and units is premature until the reasons why some hospitals have been adversely affected by the rate-of-increase limits and others have received substantial incentive payments are more fully understood.

Comment: Two commenters oppose our recommendation that the costs of new technology should be offset by productivity gains. These commenters believe that the TEFRA system provides an automatic sharing of productivity gains between the facility and HCFA, through the capping of hospital gains, when the facility's costs are less than its target amount. These commenters believe that no additional productivity adjustment is warranted.

Response: As a systemwide standard, we believe that increased costs for quality-enhancing new technologies should be offset by productivity gains and that explicit adjustments in the rate-of-increase limit for productivity and new technology are inappropriate. The sharing of gains when the target amount exceeds cost is based on individual hospital behavior above and beyond the standard we believe all excluded facilities should meet.

Appendix D: Development of Update Framework for Prospective Payment System for Inpatient Hospital Capital-Related Costs

I. Introduction

For FY 1992 through FY 1995, § 412.308(c)(1) provides that the update for the capital prospective payment rates (Federal rate and hospital-specific rate) will be based on a 2-year moving average of actual increases in Medicare inpatient capital costs per discharge. Beginning in FY 1996, the regulations provide that HCFA will determine the update in the capital prospective payment rates based on an analytical framework that will take into account (1) changes in the price of capital (which we will incorporate into a capital input price index), and (2) appropriate adjustments to account for changes in capital requirements, such as the development of new technologies, diffusion of existing technologies, existing hospital capacity and

utilization, and other factors. The objective of the update framework is to provide a rate of increase in aggregate capital prospective payments which, along with a rate of increase in DRG payments, ensures a joint flow of capital and operating services for efficient and effective care for Medicare patients.

Although the analytical framework will not be employed to determine the annual update factor until FY 1996, we are presenting a preliminary model, using available data and concepts, of an update framework for the capital prospective payment system. The preliminary update framework below includes a capital input price index which parallels the operating input price index. The capital input price index measures the changes in input prices for capital-related costs necessary to maintain the composition of capital in the base year. The composition of capital is the mix of capital inputs, that is, the mix of type, quantity, and age of capital, as well as a proportion of expenses for movable equipment and for buildings and fixed equipment. As such, the composition of capital reflects the underlying capital acquisition process. For consistency with the operating input price index, we have selected 1987 as the base year for this preliminary capital input price index. We would periodically update both the operating and the capital input price indexes to reflect the changing composition of inputs for capital and operating costs. We expect to have rebased the capital and operating input price indexes by the time we implement the final capital update framework for FY 1996. The preliminary capital input price index below illustrates the methodology we propose to employ.

The preliminary capital update framework, like the proposed operating update framework, incorporates several policy adjustments in addition to the capital input price index. We would adjust for case-mix index-related changes, for intensity, and for the efficiency and cost-effective use of capital (i.e., movable equipment, buildings and fixed equipment, etc.) in the hospital industry, as well as for error in the capital input price index forecast.

We have developed the following model of a capital prospective payment system update framework in conjunction with the proposed changes to the operating prospective payment system framework discussed in appendix C. In developing this model, we have attempted as much as possible to maintain consistency with the proposed operating framework in order to facilitate the eventual development of

a single prospective payment system update framework. We have also been concerned to promote the goals that motivated the adoption of a prospective payment system for inpatient capital-related costs, especially the goals of promoting more effective and efficient utilization of capital resources in the hospital industry and establishing incentives for hospitals to make cost-effective decisions regarding acquisition of new capital resources.

It is important to emphasize that this presentation represents our current thinking, and that we encourage submission of comments and recommendations for improvements. We are especially interested in suggestions regarding the capital input price index, the adequacy of the proposed policy adjustment factors, and alternative methodologies for deriving the factors. We are also interested in information concerning empirical studies and sources of data that could be useful in developing the framework. Comments should be sent by December 31, 1992 to: Update Framework, Division of Hospital Payment Policy, 1-H-1 East Low Rise, 6325 Security Boulevard, Baltimore, Maryland 21207.

In conjunction with the prospective payment system rule-making processes for FY 1994 and FY 1995, our current plan is to provide successively more developed models based on our further study of the conceptual and empirical foundations of the framework and on our evaluation of the comments and recommendations submitted in response to this preliminary discussion. However, in view of ProPAC's recommendation that we implement a capital update framework beginning in FY 1994, we also invite public comment on this issue.

II. Measurement of Capital Input Price Increases

A. Introduction

Our capital update framework would utilize a capital input price index to parallel the existing operating input price index. Both indexes measure price aspects of changes in input resources. The operating expense input price index measures per unit price changes in labor and other non-capital materials and services; the capital input price index measures the price changes in capital-related expenses per unit of real capital still in use.

The capital input prices index would differ from the operating input price index in one respect. The operating input price index measures changes in costs related to flows of labor and non-capital goods and services over time.

The proposed capital input price index would measure changes in costs related to stocks of real capital assets rather than costs related to flows of capital services.

The stock of capital is the physical quantity of depreciable resources whose nominal and/or real value is measured annually (for example, at the end of a fiscal or calendar year). Depreciable capital includes movable equipment, buildings, and other manufactured, non-labor resources that have a useful life of two years or more.

A hospital uses capital services generated by capital stocks to produce outputs. The flow of capital services is measured over time. For example, flow of x-ray machine services is measured as the number of available x-ray machine hours over a given period of time.

It is the flow of capital services (for example, the number of available x-ray machine hours), not the stock of capital (for example, the nominal and/or real value of the x-ray machines), that is most relevant to hospital production. It would therefore be desirable to measure capital-related expenses related to flows of capital services. Measuring flows of capital services would also preserve a more complete parallel with the operating input price index. However, it is necessary to measure capital-related expenses related to stocks of real capital assets because no information on the flow of hospital capital services is currently available. In the absence of such information, we assume that the flow of capital services per unit of real capital stock has remained constant over time, and that, therefore, the ratio of changes in capital-related costs per unit of real capital stock is an appropriate measure of change in a capital input price index.

We selected 1987 as the base year for the capital input price index to parallel the operating input price index. The most recent rebasing of the operating input price index employed relative weights from the year 1987. Employing the same base year for the capital input price index will facilitate the eventual development of a joint update framework for capital and operating expenses. We will rebase the capital input price index periodically in conjunction with the rebasing of the operating input price index to account for the changing composition of capital stock.

B. Consistency with the Capital Acquisition Model

The capital input price index uses weights, asset life assumptions, and financing patterns derived from the

capital acquisition model developed for the August 31, 1990 final rule (see 56 FR 43417-43422). Since the model successfully reproduced Medicare capital costs per discharge distributions among hospitals, and since the model was designed to be consistent with observed capital patterns, we believe that it is a good source of weighting factors for the capital input price index.

- Three categories of capital-related expenses for owner-operated capital are considered in the index, including depreciation, interest, and other expenses (capital-related taxes and insurance). Since leases and rentals are a substitute for owner-operated capital, and since cost increases for leases and rentals are assumed to grow at a rate similar to owner-operated capital, we implicitly included leases and rentals in rates of change for the depreciation and interest categories. We are currently studying cost patterns for leases and rentals. After further study, we may continue to treat leases and rentals like depreciation and interest, or we may treat them separately in another category if we are able to determine an appropriate price proxy for leases.

- Two categories of straight-line depreciation expense are recognized, including depreciation expense for buildings and fixed equipment and depreciation expenses for movable equipment.

- In determining depreciation amounts, we adopted a 25-year useful life for building and fixed equipment and a 7-year useful life for movable equipment.

- In determining interest amounts, we adopted an expected 20-year life for debt instruments associated with the purchase of buildings and fixed equipment and an expected 6-year life for debt instruments associated with the purchase of movable equipment.

- We incorporated an amortization adjustment to interest costs to account for effects of aging of the debt instrument.

- The relative expenditure weights for owner-operated capital expenses by type of capital-related expense in the 1987 base year were .655 for depreciation, .295 for interest, and .050 for other capital-related expenses (taxes and insurance). In 1987, the relative internal expenditure weights for depreciation amounts were 54.0 percent for building and fixed equipment depreciation and 46.0 percent for movable equipment depreciation. In 1987, the relative internal expenditure weights for interest amounts by type of debt instrument were 85.4 percent for debt instruments related to building and fixed equipment purchases and 14.6

percent for debt instruments related to movable equipment purchases. The full complement of relative expenditure weights for the capital input price index are, therefore, as follows:

RELATIVE EXPENDITURE WEIGHTS

Type of Expense	Relative weight
Depreciation:	
Building and fixed equipment.....	.354
Moveable equipment.....	.301
Interest:	
Building and fixed equipment.....	.252
Moveable equipment.....	.043
Other Capital-related Expenses.....	.050
	1.000

We will continue to study all relative expenditure weights for appropriateness.

Since the capital input price index is intended to measure price changes in capital-related costs per unit of real capital assets over time, we examined the determinants of price change in each of the major components of capital-related costs. Below we present a discussion of each of these components: depreciation, interest, and "other" capital-related costs.

C. Depreciation

Current depreciation costs represent the sum of the depreciation costs for all items of currently depreciable capital stock. The depreciation cost for each item is determined by dividing the nominal (actual) purchase price by the useful life of the item. We assume that the useful life of the stock for a particular category of assets does not change over time and that the same amount of depreciable real capital stock was purchased in each year starting with the current year back to the year representing the earliest year in the useful life of the stock type. Since the nominal amount of all past purchases of currently depreciable capital stock is the purchase price per unit of stock multiplied by the amount of real capital stock purchased, depreciation costs per unit of real capital stock change under our assumptions only because the average purchase price of currently depreciable assets change.

Some capital stock currently in use was fully depreciated before the current period and thus there are no current depreciation costs associated with such capital stock. Therefore, the depreciation portion of our capital input price index, which measures changes in capital costs per unit of capital stock still in use, requires some estimate of the changes in the proportion of total capital

still in use which represents fully depreciated capital stock. We assume that the proportion remains constant over time and, therefore, is not a factor in the capital input price index.

For purposes of developing the capital input price index, we selected the building cost index derived and maintained by the Engineering News-Record (ENR) as the best currently available source of measuring changes in costs of fixed assets. The ENR building index is published monthly by the Bureau of Economic Analysis in its Survey of Current Business (Current Business Statistics). This index tabulates surveyed cost changes in 20 cities for three major building categories and three classifications of skilled tradesmen predominantly utilized by the construction industry. The ENR index assigns aggregate weights to fixed quantities of structured steel, Portland cement, and lumber. In the labor component, it calculates an average wage paid to carpenters, bricklayers, and structural ironworkers. The actual weights are based on the relative importance of the various components in construction that were obtained from a survey of construction authorities. Because the ENR index deals only with the effects of trends in wage rates and material prices, it is considered an appropriate means of updating the fixed asset component of the hospital input price index. (A number of other indexes were reviewed and evaluated for use, including some hospital or health-specific measures. This board-based index met several criteria. We are continuing research in this area.) A 25-year moving average in this index provides rates of change in average purchase prices for currently depreciable building and fixed capital stock.

For purposes of developing the capital input price index, we selected the percentage change in the cost of machinery and equipment as measured by the Producer Price Index (SIC code #11) as the best currently available source for measuring changes in the purchase price of movable equipment. The index is published monthly by the U.S. Department of Labor, Bureau of Labor Statistics, in the Monthly Labor Review. We selected this broad based index of machinery and equipment as a price proxy for all hospital movable assets because it encompasses a wide range of heavy duty electrical and mechanical products. Included in the array of manufactured products are furnaces and ovens, power tools and accessories, pumps and compressors, scales and balances, elevators, and air-

conditioning and refrigeration equipment. Many electrical product components are also evaluated within this variable. Of special note, this proxy incorporates x-ray equipment and other testing and measuring instruments, as well as commercial laundry equipment. A 7-year moving average in this index provides rates of change in average purchase prices for currently depreciable movable capital stock.

D. Interest

Current interest costs represent the sum of all interest costs related to past debt instruments that are still alive. Thus, current interest costs are the product of:

- Nominal amounts of all past purchases of capital stock within the expected life of the debt instruments. These nominal amounts are the product of the average purchase price per unit of capital stock multiplied by the number of units of real capital stock purchased;
- The proportion of the nominal purchase amounts that were financed by debt (and not by equity financing). Current evidence from Medicare Cost Reports indicates that this proportion has remained constant over time and, therefore, is not a factor in changing interest costs per unit of capital stock;
- The amortized interest patterns in the periodic debt payment as a function of the interest rate applicable on the loan, the life of the debt instrument, and the age of the debt instrument;
- The proportion of the debt which represents interest costs in the current period (a function of the interest rate applicable to the loan, the life of the debt instrument, and the current age of the debt instrument).

In the capital input price index, where our concern is interest costs per unit of real capital still in use, we assume that the amount of real capital stock implicit in any debt instrument as a proportion of real capital stock still in use remains constant over time and, therefore, is not a factor of change in the capital input price index.

The interest component of the capital input price index is therefore composed of the summed changes in the product of past purchase prices, past interest rates, and current amortized effects of past interest rates.

The external price proxy used to represent interest rates in the capital input price index is a weighted average of the percentage changes for two interest rate series:

- The average yield on domestic municipal bonds, Daily Bond Buyer (20 bonds) is given a 85 percent weight; and

- The average yield on Moody's AAA corporate bonds is given a 15 percent weight.

Data for municipal and corporate bonds is published by the U.S. Department of Commerce, Bureau of Economic Analysis (BEA), in the Survey of Current Business, Finance Section. BEA publishes the yield on the Thursday nearest the end of the month.

The internal weights applicable to each bond type were estimated from long term debt data reported in Medicare cost reports by type of hospital control. Percentage changes in the municipal bond rate approximate interest rate changes paid by the non-profit and government sectors of the industry and the percentage changes in the AAA bond rate approximate interest rate changes paid by the for-profit sector. A 20-year moving average of the product of this composite interest rate and the price proxy for building and fixed equipment, adjusted for amortization, provides a measure of change in interest costs per unit of building and fixed capital stock. A 6-year moving average of the product of this composite interest rate and the price proxy for movable equipment, adjusted for amortization, provides a measure of change in interest costs per unit of movable capital stock.

E. Other Capital-Related Costs

In addition to depreciation and interest, which account for the bulk of capital costs, there are several other relatively minor cost expenditures that are considered capital-related. Payments for fire and allied property insurance, and real estate taxes all fall within this category. A measurement of rent costs would implicitly recognize these related cost factors, and thus reflects changes in costs for the "other" capital-related costs. Since no commercial rental proxy exists, residential rental is a reasonable proxy that can, over time, reflect the trend in price movements of the residual capital-related costs. We used the residential rent component of the Consumer Price Index for All Urban Consumers as a price proxy for this component. This index is prepared by the U.S. Department of Labor, Bureau of Labor Statistics, and is published monthly in the Monthly Labor Review.

F. Review of Data Sources

We continue to explore data sources and applications in order to refine and to improve the weights and price proxies in our capital input price index. We use at least three basic criteria to evaluate price proxies to enter into our price

indexes: The price proxy data must be publicly available, it must be based in valid sampling designs, and it must have been collected for a sufficiently long period of time to ensure stability and credibility. These criteria exclude a number of proprietary and anecdotal data bases and other recently devised indexes that are frequently cited as

alternatives to the price proxies which we selected.

Although we have selected the best price proxies currently available to us under these criteria, we are aware that other price proxy data bases may exist which are superior to those we have chosen. Therefore, we invite suggestions and recommendations for any changes which may be required.

G. An Application

We have combined the weights and price proxies discussed previously in Table 1 to produce annual rates of change in our proposed capital input price index. The price projections used in this exercise were prepared by Data Resources Inc., a forecasting service engaged by the Health Care Financing Administration.

TABLE 1.—CAPITAL INPUT PRICE INDEX: PERCENT CHANGE FOR TOTAL INDEX AND FOR INDEX COMPONENTS, FEDERAL FISCAL YEARS 1987 TO 1997

	Total	Depreciation		Interest		Other
		Fixed	Movable	Fixed	Movable	
1987 Weights	1.000	0.345	0.301	0.252	0.043	0.050
Fiscal Year:						
1987	4.5	5.8	3.8	5.3	-6.2	4.5
1988	4.2	5.6	2.8	5.5	-4.0	3.8
1989	3.8	5.4	2.3	4.3	-2.8	3.8
1990	3.7	5.2	2.3	3.9	-1.8	4.2
1991	3.5	5.0	2.3	3.2	-0.7	3.9
1992	3.1	4.9	2.1	2.5	-0.6	2.6
1993	3.0	4.7	2.1	2.5	0.6	2.0
1994	3.1	4.5	2.3	2.3	1.3	3.8
1995	3.0	4.4	2.5	1.9	1.5	3.4

NUMBER OF YEARS IN MOVING AVERAGES

Depreciation	
Fixed	25
Movable	7
Interest	
Fixed	20
Movable	6
Other	Not Applicable

Interest Rate Adjusted for Purchase Price and for Amortization.

Source: Health Care Financing Administration.

III. Case-Mix Adjustment and Adjustment for Forecast Error

The case-mix index (CMI) is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the CMI corresponds to an equal percentage increase in hospital payments.

The case-mix index is the measure of the average DRG weight. The case-mix index can change for any of several reasons: because the average resource use of Medicare patients changes ("real" case-mix change), because changes in hospital coding of patient records result in higher weight DRG assignments ("coding effects"), and because the annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect"). In the current framework, we adjust the update upward to reflect increases in real case mix, but remove the effects of coding. In addition, we remove the effect on total

payments of changing the DRG classifications and relative weights, in order to retain budget neutrality for all changes other than patient severity and the update.

In the present update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all CMI-related changes other than patient severity (for example, we adjusted for the effects of the FY 1991 recalibration and reclassification as part of our FY 1993 update recommendation). The proposed operating framework retains these adjustments. The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We would adopt this CMI adjustment as well in the capital update framework.

The proposed operating update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the following year. In any given year there can be unanticipated price

fluctuations that can result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. We therefore believe that the capital update framework should also include a forecast error adjustment factor. In setting a prospective payment rate under the proposed framework, we would make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. Thus, for example, in determining whether to make a forecast error adjustment in FY 1993, we would look at the forecast error for FY 1991.

IV. Policy Adjustment Factors

The capital input price index measures the changes in input prices for capital-related costs necessary to maintain the composition of capital in the base year. We would address through the policy adjustment factor appropriate changes in the amount and composition of capital stock.

The existing update framework for the prospective payment system for operating costs includes factors designed to adjust the input price index rate of increase for policy considerations. Appendix C describes the revised policy adjustment factors that we are proposing for the operating framework. Under the proposed operating framework, we would adjust for service productivity (the efficiency with which providers produce individual

services such as laboratory tests and diagnostic procedures) and intensity (the amount of services used to produce a discharge).

The proposed service productivity factor for the operating update framework would reflect a forward-looking adjustment for the changes that hospitals can be expected to make, on the basis of a normative standard, in service-level productivity during the year. A hospital would retain any productivity increases above the average.

The intensity factor for the operating update framework would reflect how hospital services are utilized to produce the final product—the discharge. This component would account for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services. We intend the quality-enhancing practice component to recognize the use of services that increase cost but whose value in terms of enhanced health status is at least commensurate with those costs. The component for real within-DRG change is intended to capture changes in resource requirements resulting from increases in case complexity within DRGs. The real within-DRG component allows hospitals to be compensated for this otherwise unmeasured portion of real case-mix change. The component for reduction in cost-ineffective practice recognizes that some improvements in practice patterns could be made so that the intensity of services provided is more consistent with the efficient use of limited resources. We intend this component to encourage both hospitals and physicians to consider more carefully the cost-effectiveness of medical care.

We believe that the proposed intensity adjustment factor can be adopted in the capital update framework. Under the proposed operating update framework, we would calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component) and changes in real case mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. We can therefore incorporate the proposed intensity adjustment from the operating update framework into the capital update framework. We know of no reliable estimates of the proportions of the overall annual intensity increases

that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity. We would therefore assume, as in the proposed operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework would thus provide an addition to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG complexity and the adoption of quality-enhancing technology.

Productivity is intrinsically a multi-factor concept. In our proposed operating update framework, we allocate a share of productivity to labor according to labor's share of total inputs, as calculated in the input price index for the prospective payment system for operating costs. We considered developing a multi-factor productivity measure for use both in the proposed operating update framework and in the capital update framework. However, we lack an adequate measure of the flow of capital services from capital inputs for use in developing such a measure. In the absence of an adequate multi-factor productivity measure based on the flow of capital services, we are unable to propose a single productivity adjustment adequate for use in both frameworks.

Other considerations suggest that the capital update framework should incorporate a productivity adjustment distinct from the measure employed on the operating side. Operating inputs are more variable and adjustable in the short run. The productivity target incorporated into the proposed operating framework thus operates on a short-run, year-to-year basis. We believe that there should also be targets for improved efficiency and effectiveness of capital, but capital efficiency and effectiveness targets must be on a longer-run basis. This is because the level of capital inputs is generally fixed in the short run, and therefore longer periods of time are needed to adjust these inputs to levels consistent with cost-effective output, that is, to achieve longer-run productivity improvements. We believe that the capital update framework should incorporate an adjustment for long-run efficiency and cost-effectiveness. Such an adjustment would require a long-run concept of the efficient and cost-effective level of capital resources.

In developing an adjustment for the long-run efficiency and cost-effectiveness of capital (movable equipment, buildings and fixed

equipment, etc.), we believe that we should take into account that the existing resources of the hospital industry are not being used with sufficient efficiency and effectiveness. Prior to the adoption of the prospective payment system for capital-related costs, Medicare payment policy for capital-related costs, as well as the policies of other payers, did not provide sufficient incentives for efficient and cost-effective capital spending. As a result, capital costs per case, and therefore base year prospective capital rates, may be higher than would have been consistent with capital acquisition policy in more efficiency-oriented competitive markets. Volume and intensity of capital acquisition have far outpaced the increase in capital input prices during the years between the implementation of the prospective payment system for operating costs and the introduction of the capital system. Hospitals may have responded to the incentives of the cost-based reimbursement system for capital by expanding beyond what was necessary for efficient and cost-effective delivery of services.

As a preliminary examination of this issue, we analyzed the change in actual Medicare capital cost per case for the years 1986-1991 in relation to the change in the capital input price index (which accounts for change in the input prices for capital-related costs), and the other adjustment factors we propose to include in the framework, for which we currently have measures, that is, the increase in real case mix, and the increase in intensity due to quality-enhancing technological change and within-DRG complexity. We could not, of course, include any adjustment for efficiency since we have not identified an appropriate measure. We found rates of increase in spending per case that exceeded the rate of increase attributable to inflation in capital input prices, quality-enhancing intensity increases, and real case mix growth. (These numbers would be higher or lower if an efficiency adjustment were included). From a high of 11.4 percent in 1986, the residual increase over inflation, quality-enhancing intensity increases, and real case mix growth fell until 1988. In that year, the increase in the average cost per case was only 0.7 percent greater than the rate of increase in inflation, intensity, and real case mix growth. However, the residual increase in cost rose again beginning in 1989. It rose from 1.3 percent in 1989 to 4.3 percent in 1990 before declining again to 2.7 percent in 1991. Cumulatively, the residual of actual increases in average

cost per case over increases in cost attributable to inflation, intensity, and real case mix from 1986 to 1991 was 28.9 percent.

CUMULATIVE PERCENTAGE CHANGE IN COST PER CASE DUE TO INFLATION, REAL CMI, AND INTENSITY, 1986-1991

Year	Capital price index ¹	Real CMI ²	Allowable intensity ³	Resulting increase ⁴	Actual % change cost/case ⁵	Residual ⁶
1986	5.4	1.7	1.7	9.0	21.4	11.4
1987	4.5	1.3	2.4	8.4	14.8	5.9
1988	4.2	1.1	1.4	6.8	7.6	0.7
1989	3.8	1.3	0.3	5.5	6.8	1.3
1990	3.7	1.1	0.2	5.1	9.6	4.3
1991	3.5	1.0	0.1	4.6	7.5	2.7
Cumulative (compounded)				46.3	88.7	28.9

¹ Figures for 1987 to 1991 are from Table 1, Part B; the figure for 1986 was supplied separately by HCFA OACT.

² Assuming that real CMI is one-half of observed CMI.

³ One-half of observed intensity increase as determined by the methodology of the proposed joint operating/capital intensity measure.

⁴ The increase attributable to inflation, real CMI, and allowable intensity, calculated as the product of the rates of increase of those factors (i.e., $1.054 \times 1.017 \times 1.017 = 1.09$ for 1986).

⁵ Figures supplied by HCFA's Office of the Actuary.

⁶ The actual increase in average cost per case divided by the appropriate increase in cost (i.e., $1.214/1.09 = 1.114$, a residual of 11.4% for 1986).

If real CMI growth is assumed to be 1.0 percent annually, rather than half of observed case mix, the cumulative residual of actual increases in average cost per case would be 30.0 percent. Therefore, we believe that the long-run adjustment for capital efficiency and cost-effectiveness should take into account the efficiency and effectiveness of the capital resources present in the base year for the prospective payment system for capital-related costs. We do not believe that Medicare capital payment rates should provide for maintenance of capital in excess of the

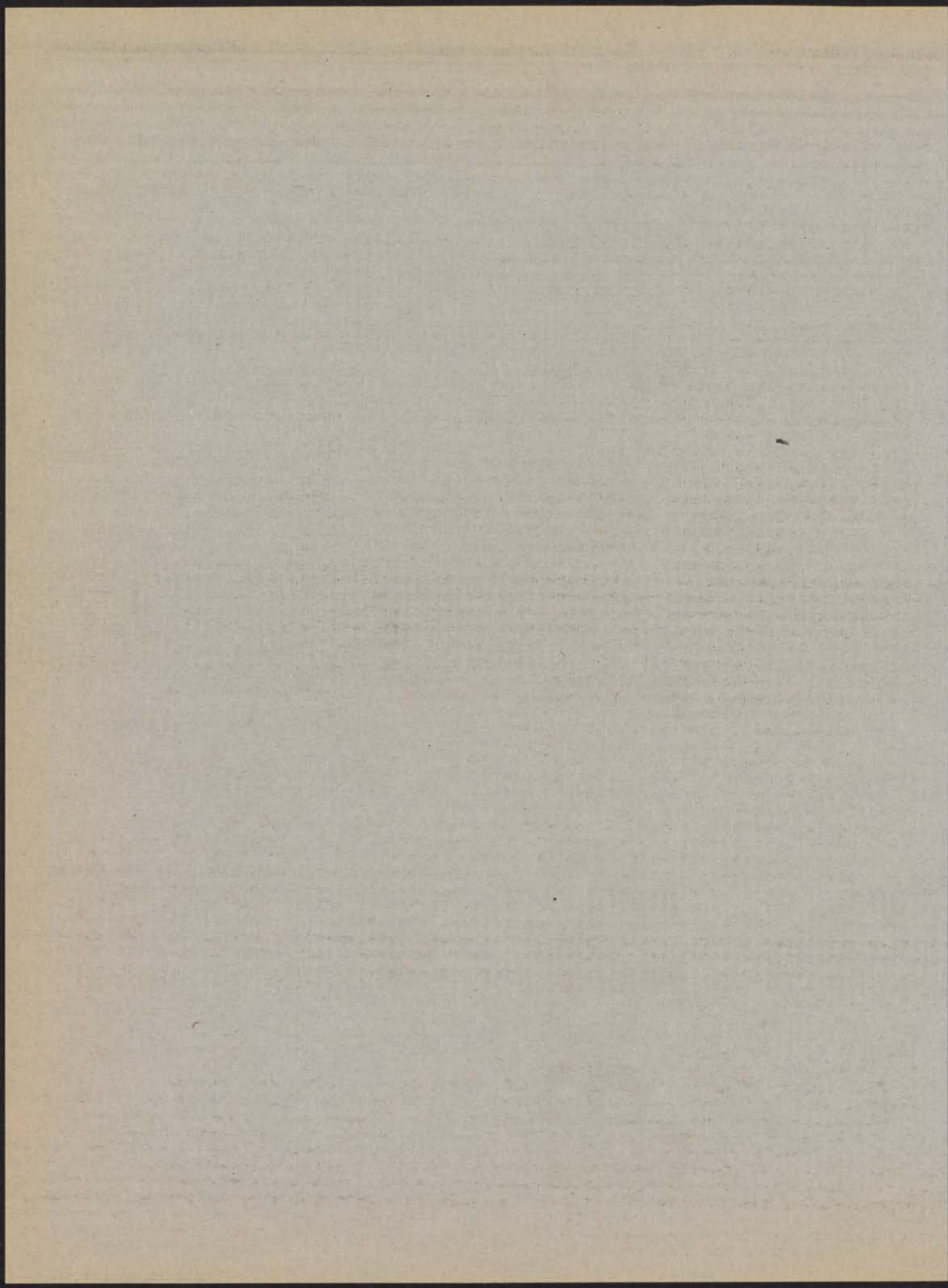
level that would be produced in an efficiency-oriented competitive market. The capital productivity adjustment should be designed to give hospitals an incentive to reduce inefficiency and ineffectiveness in capital resources. At the same time, the estimate for long-run productivity must allow for enhancements in capital resources as existing capital resources deteriorate. At this time, we are beginning to evaluate alternative efficiency measures. We welcome comments and recommendations on the merits of such an adjustment and on methodologies

and factors for determining the amount of the adjustment.

Finally, we are aware that certain geographic areas may, during the coming years, experience insufficient bed supply for their Medicare populations. We solicit comment on the unique capital problems of these geographic areas in assuring a sufficient bed supply in a budget neutral manner. We do not intend to make any facility-specific adjustments.

[FR Doc. 92-20647 Filed 8-31-92; 8:45 am]

BILLING CODE 4120-03-M



Tuesday,
September 1, 1992

**Administrative
Committee of the
Federal Register**

Part III

**Administrative
Committee of the
Federal Register**

1 CFR Parts 2, 3, and 11

**Price Changes to Federal Register
Publications and Relocation of the Office
of the Federal Register; Final Rule**

ADMINISTRATIVE COMMITTEE OF THE FEDERAL REGISTER

1 CFR Parts 2, 3, and 11

Price Changes to Federal Register Publications and Relocation of the Office of the Federal Register

AGENCY: Administrative Committee of the Federal Register.

ACTION: Final rule with request for comments.

SUMMARY: The Administrative Committee of the Federal Register (ACFR) announces increases in the prices of Federal Register publications. The price changes apply to annual subscription rates for the daily Federal Register, the Code of Federal Regulations (CFR), and the Weekly Compilation of Presidential Documents, as well as to the single issue price of the daily Federal Register. The price increases are necessary to more accurately reflect the Government's cost of production and distribution of these publications. This rule also changes the street address listed for the Office of the Federal Register in ACFR regulations.

DATES: The changes to 1 CFR 11.2 (Federal Register prices) and to 1 CFR 11.6 (Weekly Compilation of Presidential Documents prices) are effective October 1, 1992. The changes to 1 CFR 11.3 (CFR prices) are effective January 1, 1993. The technical amendments to 1 CFR 2.3(b) and 3.2(a) (Office of the Federal Register address) are effective July 20, 1992. Comments will be accepted until January 1, 1993.

ADDRESSES: Street Address: 800 North Capitol Street, NW., suite 700, Washington, DC 20002-4246. Mailing address: Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408.

FOR FURTHER INFORMATION CONTACT: Michael White at (202) 523-4534.

SUPPLEMENTARY INFORMATION: The Administrative Committee of the Federal Register, which establishes prices for Federal Register publications, has recently determined that price adjustments must be made to move toward full cost recovery for production and distribution of these publications. The prices charged for the Federal Register in paper format have remained constant at \$340 per year for a subscription and \$1.50 per single issue since October 1988; the price of a subscription to the Weekly Compilation of Presidential Documents was set at \$55 in October 1988; and the subscription rate for the paper edition of the Code of Federal Regulations (CFR)

was set at \$620 in January 1989. In the years since these prices were set, the Administrative Committee has taken note of substantial escalations in the costs of production at the Government Printing Office plant, as well as major postal rate increases. The microfiche editions of the Federal Register and the CFR are subject to a competitive bidding process that determines the prices charged.

To lessen the effect of price increases on Federal Register customers, the Administrative Committee has decided to work toward achieving full recovery of current and anticipated expenditures by phasing in price changes over several years.

In addition, the Committee will offer Federal Register subscribers the economy and flexibility of a basic subscription consisting of only the daily issues of the Federal Register. The basic Federal Register subscription will not include the Federal Register Index and List of CFR Sections Affected (LSA). Subscribers wishing to augment the basic subscription will have the option of ordering these publications as separate items or as part of a combined Federal Register subscription. The prices charged for individual copies of the Federal Register Index and the LSA will remain unchanged.

The Administrative Committee will meet annually to assess production and distribution costs and will take further incremental steps as necessary to achieve full cost recovery for the Federal Register program. The Committee welcomes comments on the pricing structure of Federal Register publications and its intent to seek full cost recovery.

The following rates are effective as of October 1, 1992. The annual subscription rates for the Federal Register paper edition will be \$375, or \$415 for a combined Federal Register, Federal Register Index and LSA subscription. The microfiche edition of the Federal Register including the Federal Register Index and LSA will be \$353. Single copies of the paper edition of the daily Federal Register will be \$4.50. The annual subscription rate for the Weekly Compilation of Presidential Documents will be \$96 by first-class mail or \$58 by non-priority mail.

As of January 1, 1993, the annual subscription rates for the Code of Federal Regulations will be \$775 for the paper edition and \$223 for the microfiche edition.

In this rule, the Administrative Committee also makes technical amendments to 1 CFR 2.3(b) and 3.2(a) to reflect the relocation of the Office of the Federal Register to 800 North Capitol

Street, NW., suite 700, Washington, DC. The mailing address for the Office of the Federal Register will continue to be: Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408.

The Administrative Committee has not published a notice of proposed rulemaking on the revised price schedule, as allowed by 5 U.S.C. 553(b)(3) when there is good cause not to publish a proposed rule and obtain comments from interested persons.

The Administrative Committee has determined that publication of a proposed rule is unnecessary for the following reasons. The Administrative Committee has authority under 44 U.S.C. 1506 to set the price to be charged for copies of, and subscriptions to, the Federal Register. To the extent possible the Administrative Committee sets prices to reflect the actual cost of producing and distributing Federal Register publications. The revised prices are based on an in-depth cost study conducted for the Administrative Committee by the Government Printing Office. Because only actual costs were considered in setting the revised price schedule based on an in-depth cost study, the Administrative Committee has determined that there is good cause for promulgating this final rule without a prior notice of proposed rulemaking.

This is not a major rule under Executive Order 12291. The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) does not apply to rate increases necessary to recover the costs to the Government of printing and distributing these publications.

List of Subjects in 1 CFR Parts 2, 3 and 11

Federal Register publications, Government publications, Organization and functions (Government agencies), Subscription rates.

For the reasons discussed in the preamble, the Administrative Committee of the Federal Register amends parts 2, 3, and 11 of chapter I of title 1 of the Code of Federal Regulations as set forth below:

PART 2—GENERAL INFORMATION

1. The authority citation for part 2 continues to read as follows:

Authority: 44 U.S.C. 1506; sec. 6, E.O. 10530, 19 FR 2709, 3 CFR, 1954-1958 Comp., p. 189; 1 U.S.C. 112; 1 U.S.C. 113.

§ 2.3 [Amended]

2. In § 2.3(b), revise the address "1100 L Street NW., Washington, DC" to read

"800 North Capitol Street, NW., suite 700, Washington, DC".

PART 3—SERVICES TO THE PUBLIC

1. The authority citation for part 3 continues to read as follows:

Authority: 44 U.S.C. 1506; sec. 6, E.O. 10530, 19 FR 2709, 3 CFR, 1954-1958 Comp., p. 189.

§ 3.2 [Amended]

2. In § 3.2(a), revise the phrase "in Room 8301, 1100 L Street NW., Washington, DC" to read "at 800 North Capitol Street, NW., suite 700, Washington, DC".

PART 11—SUBSCRIPTIONS

1. The authority citation for part 11 continues to read as follows:

Authority: 44 U.S.C. 1506; sec. 6, E.O. 10530, 19 FR 2709, 3 CFR, 1954-1958 Comp., p. 189.

2. Section 11.2 is revised to read as follows:

§ 11.2 Federal Register.

Daily issues are furnished by mail to subscribers for \$375 per year in paper

form. A combined subscription consisting of the daily issues, the monthly *Federal Register Index* and the LSA (List of CFR Sections Affected) is furnished by mail to subscribers for \$415 per year in paper form or \$353 per year in microfiche form. The daily issues are available on magnetic tape for \$37,500 per year. Six-month subscriptions are also available at one-half the annual rate. Limited quantities of current or recent issues may be obtained for \$4.50 per copy in paper form, \$1.50 per copy in microfiche form, or \$175 per copy in magnetic tape form.

3. Section 11.3 is revised to read as follows:

§ 11.3 Code of Federal Regulations.

A complete set is furnished by mail to subscribers for \$775 per year for the bound, paper edition; \$223 per year for the microfiche edition; or \$21,750 per year for the magnetic tape edition. Individual volumes of the bound, paper edition of the Code are sold at prices determined by the Superintendent of

Documents under the general direction of the Administrative Committee. The price of an individual volume in microfiche form is \$2.00 per copy or \$125 per magnetic tape.

4. Section 11.6 is revised to read as follows:

§ 11.6 Weekly Compilation of Presidential Documents.

Copies in paper form are furnished to subscribers for \$96 per year by first-class mail or \$58 per year by non-priority mail. The price of an individual copy in paper form is \$2.00.

Don W. Wilson,
Chairman.

Robert W. Houk,
Member.

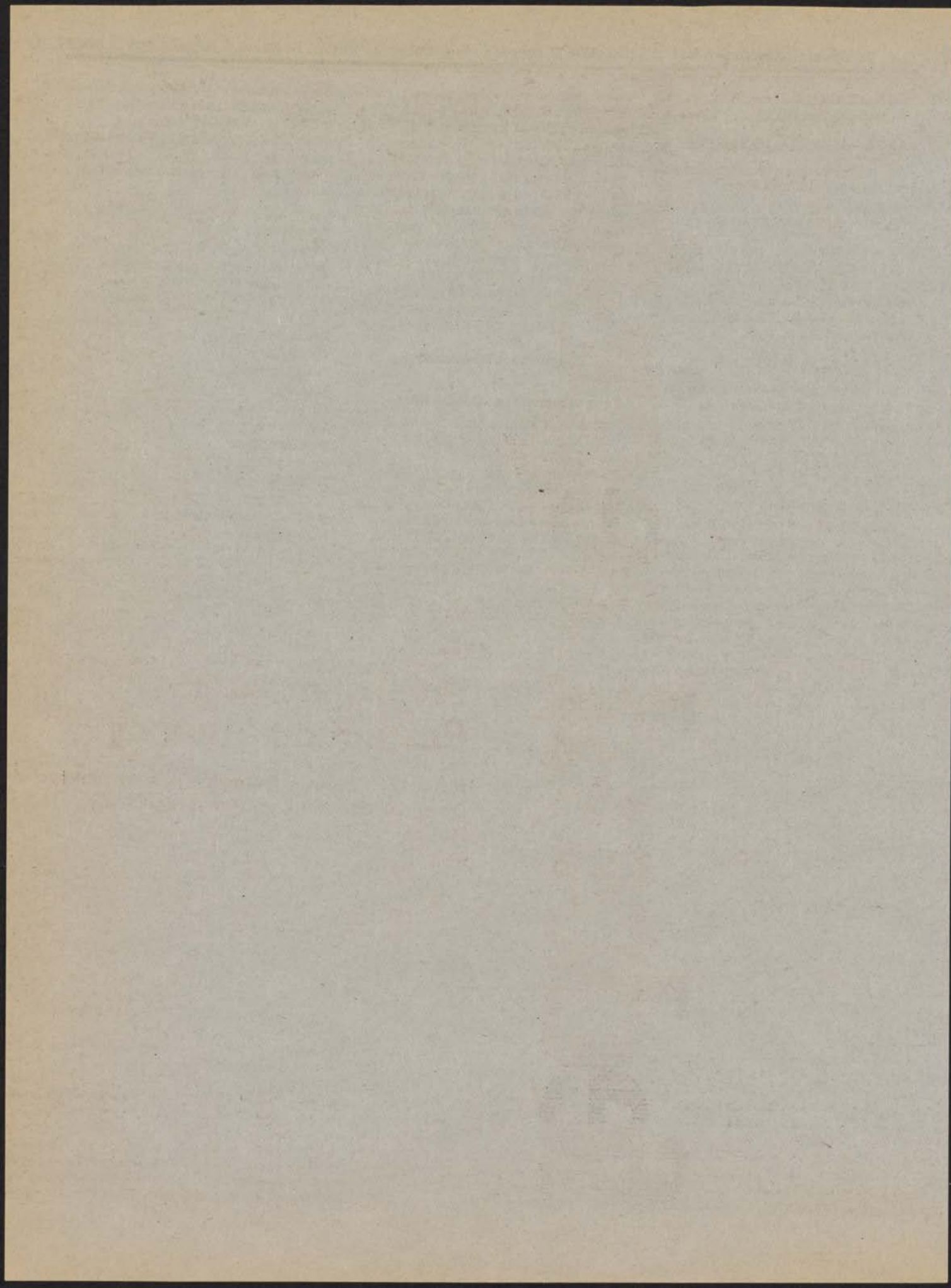
David G. Leitch,
Member.

William P. Barr,
Attorney General.

Don W. Wilson,
Archivist of the United States.

[FR Doc. 92-21084 Filed 8-31-92; 8:45 am]

BILLING CODE 1505-02-M



Estimate Report

Tuesday
September 1, 1992

Part IV

Environmental Protection Agency

Hazardous Waste: Exemption From Land
Disposal Restrictions; Allied-Signal Inc.;
Notice

ENVIRONMENTAL PROTECTION AGENCY

[FRL-4200-3]

Intent To Grant Allied-Signal Inc., a Modification of the Exemption From the Land Disposal Restrictions of the Hazardous and Solid Waste Amendments of 1984 (HSWA) Regarding Injection of Hazardous Waste

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of Intent To Grant Allied-Signal Inc., of Danville, Illinois, a Modification of the Exemption for the Injection of Certain Hazardous Wastes.

SUMMARY: The United States Environmental Protection Agency (EPA or Agency) is today proposing to grant a modification to the exemption from the ban on disposal of hazardous wastes through injection wells to Allied-Signal Inc., (Allied), of Danville, Illinois. This modification allows Allied to inject additional Resource Conservation and Recovery Act (RCRA) regulated hazardous wastes, identified by codes U211, U121, U226, and U075, through Waste Disposal Well (WDW) No. 1 if granted. The Agency currently plans to finalize the exemption for certain Toxicity Characteristic wastes, D019 and D022, when ban dates for those wastes are established. On May 8, 1990, the Agency issued Allied an exemption for injection of arsenic (D004) after determining that there is a reasonable degree of certainty that Allied's injected wastes will not migrate out of the injection zone within the next 10,000 years.

DATES: The EPA is requesting public comments on its proposed decision to exempt all of the wastes listed above. Comments will be accepted until October 16, 1992. Comments postmarked after the close of the comment period will be stamped "Late". A public hearing to allow comment on this proposed action may be scheduled if significant comments are received, and notice of this hearing will be given in a local paper and to all people on a mailing list developed by the Illinois EPA. If you wish to request that a public hearing be held, or to be notified of the date and location of any public hearing, please contact the lead petition reviewer listed below.

ADDRESSES: Submit written comments, by mail, to: United States Environmental Protection Agency, Region 5, Underground Injection Control Section (WD-17J), 77 West Jackson Street,

Chicago, Illinois 60604, Attn: Richard J. Zdanowicz, Chief.

FOR FURTHER INFORMATION CONTACT: George Hudak, Lead Petition Reviewer, UIC Section, Water Division, Office Telephone Number: (312) 353-4142, 17th floor Metcalfe Building, 77 West Jackson Street, Chicago, Illinois.

SUPPLEMENTARY INFORMATION

I. Background

A. Authority

The Hazardous and Solid Waste Amendments of 1984 (HSWA), enacted on November 8, 1984, impose substantial new responsibilities on those who handle hazardous waste. The amendments prohibit the land disposal of untreated hazardous waste beyond specified dates, unless the Administrator determines that the prohibition is not required in order to protect human health and the environment for as long as the waste remains hazardous (RCRA section 3004(d)(1), (e)(1), (f)(2), (g)(5)). The statute specifically defined land disposal to include any placement of hazardous waste in an injection well (RCRA section 3004(k)). After the effective date of prohibition, hazardous waste can be injected only under two circumstances:

(1) When the waste has been treated in accordance with the requirements of 40 CFR part 268 pursuant to section 3004(m) of RCRA (the EPA has adopted the same treatment standards for injected wastes in 40 CFR part 148, subpart B); or

(2) When the owner/operator has demonstrated that there will be no migration of hazardous constituents from the injection zone for as long as the waste remains hazardous. Applicants seeking an exemption from the ban must demonstrate either:

(a) That the waste undergoes a chemical transformation so as to no longer pose a threat to human health and the environment; or

(b) By use of mathematical models (40 CFR 148.20(a)), that fluid flow is such that injected fluids would not migrate vertically upward out of the injection zone to a point of discharge in a period of 10,000 years.

The EPA promulgated final regulations on July 26, 1988 (53 FR 28118) which govern the submission of petitions for exemption from the disposal prohibition (40 CFR part 148). A time frame of 10,000 years was specified for the demonstration not because migration after that time is of no concern, but because a demonstration which can meet a 10,000 year time frame will likely provide containment for a substantially longer time period, and also to allow time for geochemical transformations which would render the waste immobile. The Agency's standard

thus does not imply that leakage will occur at some time after 10,000 years, rather, it is a showing that leakage will not occur within that time frame.

The EPA regulations at 40 CFR 148.20(f) provide that any person who has been granted an exemption to the land disposal restrictions may request that the Agency modify the exemption to include additional wastes. If the EPA determines, to a reasonable degree of certainty, that the new wastes will behave hydraulically and chemically in a manner similar to previously exempted wastes and that injection thereof will not interfere with the containment capability of the injection zone, the modification may be granted.

B. Facility Operation

The Allied facility in Danville, Illinois, produces chlorofluorocarbon refrigerant gases. Liquid hazardous wastes containing arsenic, carbon tetrachloride, chloroform, trichlorofluoromethane, and dichlorodifluoromethane are produced as a result of this manufacturing process. Since the injection well became operational in 1973, an average of approximately 25 million gallons of hazardous waste have been disposed of per year.

C. Exemption

The modification to the exemption will allow Allied to dispose of U121 (Genetron 11), U075 (Genetron 12), U211 (carbon tetrachloride as a raw material), and U226 (waste trichloroethane) into its deep well immediately. When D019 (carbon tetrachloride) and D022 (chloroform) are banned, it is anticipated that they will be added to the list of exempted wastes.

D. Submission

On April 15, 1991, Allied submitted a request to modify its existing petition for exemption from the land disposal restrictions on hazardous waste injection under the HSWA Amendments of RCRA (40 CFR part 148). In response to Agency comments on Allied's request, Allied submitted revised documents on October 25, 1991, February 25, 1992, June 18, 1992, and July 10, 1992. The submission was reviewed by staff at the EPA and, in part, by the Illinois EPA.

II. Basis for Determination

A. Waste Description and Analysis (148.22)

The wastes to be added immediately to the exemption are defined under 40 CFR part 261 as U121, U075, U211, and U226. Genetron 11 and Genetron 12 are produced at the Allied facility and, under certain conditions can be

classified as wastes with the codes U121 and U075, respectively. Carbon tetrachloride is used as a raw material at the Allied plant, and under certain conditions can be classified as a waste with the code U211. The wastes with codes U121, U075, and U211 have not been disposed of in Allied's well in the past; however, Allied is requesting the modification to include these wastes to cover injection of recovered groundwater from groundwater remediation activities being conducted on-site, and to cover injection of other wastes containing the above mentioned compounds. Because of the impending nationwide ban on the production of chlorofluorocarbons, Allied is contemplating modifying its production activities to produce an alternate product. In so doing, it would substitute 1,1,1-trichloroethane (TCA) for carbon tetrachloride as a raw material. Waste TCA is classified as U226. Although TCA is not yet used at the Allied plant, its use is contemplated and Allied has asked for the exemption to cover this waste. Wastes which are currently proposed to be added later to the exemption are carbon tetrachloride (D019) and chloroform (D022). These wastes are currently not restricted. However, when a land disposal ban date for these two wastes is established, the EPA proposes to include them within the exemption, provided that no new information becomes available requiring reexamination of the suitability of the exemption. Comments on the acceptability of this proposal should be made at this time as no further proposal is anticipated before the exemption is modified to include these wastes.

B. Model Demonstration of No Migration

The demonstration of no migration of hazardous constituents from the injection zone involves the use of predictive mathematical models. These models were described in the Federal

Register notice for the original exemption (55 FR 5265, February 14, 1990). The only effect the addition of any of these wastes will have on the modeling is to increase the distance the waste moves vertically because of molecular diffusion. These wastes will not change the viscosity or density of the injectate, and are thus hydraulically identical to the previously modeled waste stream. Therefore, the determinations with respect to the Basic Plume Model, the Multilayer Pressure Model, and the Multilayer Vertical Permeation Model, set forth in the original exemption notice, remain valid. Only the Molecular Diffusion Model needed to be revised because of the difference in the molecular diffusion coefficients. This model was revised by calculating the diffusion coefficient in free solution for each new waste species. The diffusion coefficient was then adjusted, using the same conservative assumptions as in the original petition, to take into account movement through porous media, resulting in an effective diffusion coefficient. A new concentration reduction factor (CRF) was also calculated for each waste species by dividing the health based limit for the compound by the permit limit, except for carbon tetrachloride and chloroform, where permit limits of 50 mg/l and 300 mg/l will be imposed, respectively, as requested by Allied. Then, using Fick's second law of diffusion and the new values for the CRF and the effective diffusion coefficient, the new vertical diffusion distance was calculated. The largest diffusion distance for immediately exempt wastes is 107 feet, for TCA. The diffusion distance in the original petition was 91 feet for arsenic. Thus, diffusion movement increases only 16 feet over the originally calculated movement. After 10,000 years, the modified maximum modeled vertical extent of the waste plume is 3381 feet below ground level, rather than

3397 feet below ground level calculated in the original petition. This is still well within the originally defined injection zone, which is the top of the Eminence Formation at 3332 feet.

This maximum migration analysis was also performed for two wastes for which EPA is deferring an exemption at this time. The maximum molecular diffusion distance of D019 and D022 is 112 feet, for D022 (chloroform). Thus this additional modification will increase the calculated vertical migration distance only 5 feet over that calculated for the immediately effective exempted wastes. The top of the waste plume will move from 3381 feet below ground level, to 3376 feet below ground level, still well within the originally defined injection zone. When the ban dates are established for D019 and D022, provided of new information is received on the suitability of these wastes for exemption, the EPA will finalize an exemption modification to include these two additional wastes without reproposal or comment. However, the Agency is proposing to limit the concentration of chloroform in the wastestream to 300 mg/l at that time as a condition for the issuance of the exemption. Comments on this limitation are solicited.

III. Conditions of Petition Approval

As a condition of granting these modifications to the exemption from the ban on injection of certain hazardous wastes, the EPA will require the following conditions to be met:

- (1) Allied must remain in compliance with all conditions in its permit.
- (2) Allied must limit the concentration of carbon tetrachloride in the wastestream to 50 mg/l.

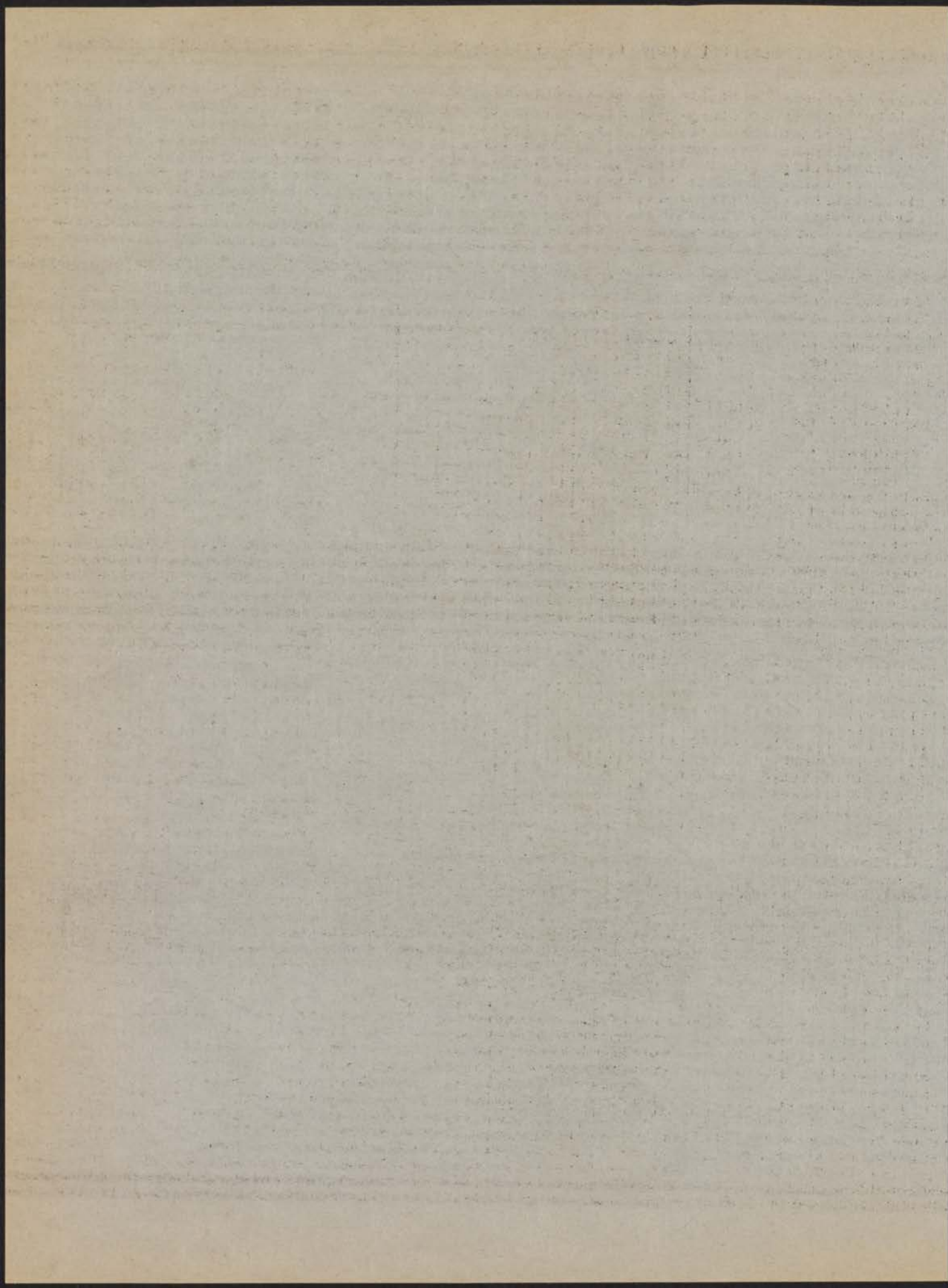
Dated: July 29, 1992.

Dale S. Bryson,

Director, Water Division, Region 5, U.S. Environmental Protection Agency.

[FR Doc. 92-20901 Filed 8-31-92; 8:45 am]

BILLING CODE 6560-50-M



50 CFR Part 20 Federal Register

Tuesday
September 1, 1992

Part V

Department of the Interior

Fish and Wildlife Service

50 CFR Part 20

Migratory Bird Hunting Regulations on
Certain Federal Indian Reservations and
Ceded Lands for the 1992-93 Early
Season; Rule

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 20

RIN 1018-AA24

Migratory Bird Hunting: Migratory Bird Hunting Regulations on Certain Federal Indian Reservations and Ceded Lands for the 1992-93 Early Season

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: This rule prescribes special early season migratory bird hunting regulations for certain tribes on Federal Indian reservations, off-reservation trust lands and ceded lands. This is in response to tribal requests for Service recognition of their authority to regulate hunting under established guidelines. This rule is necessary to allow establishment of season bag limits and, thus, harvest at levels compatible with populations and habitat conditions.

EFFECTIVE DATE: This rule takes effect on September 1, 1992.

ADDRESSES: Comments received on the proposed special hunting regulations and tribal proposals are available for public inspection during normal business hours in Room 634-Arlington Square Building, 4401 N. Fairfax Drive, Arlington, VA. Communications regarding the documents should be addressed to: Director (FWS/MBMO), U.S. Fish and Wildlife Service, Room 634-Arlington Square, Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: Dr. Keith A. Morehouse, Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Department of the Interior, room 634-Arlington Square, Washington, DC 20240 (703/358-1714).

SUPPLEMENTARY INFORMATION: The Migratory Bird Treaty Act of July 3, 1918 (40 Stat. 755; 16 U.S.C. 703 *et seq.*), authorizes and directs the Secretary of the Department of the Interior, having due regard for the zones of temperature and for the distribution, abundance, economic value, breeding habits, and times and lines of flight of migratory game birds, to determine when, to what extent, and by what means such birds or any part, nest or egg thereof may be taken, hunted, captured, killed, possessed, sold, purchased, shipped, carried, exported or transported.

In the August 7, 1992 Federal Register (57 FR 35446), the U.S. Fish and Wildlife Service (Service) proposed special migratory bird hunting regulations for

the 1992-93 hunting season for certain Indian tribes, under the guidelines described in the June 4, 1985, Federal Register (50 FR 23467). The guidelines were developed in response to tribal requests for Service recognition of their reserved hunting rights, and for some tribes, recognition of their authority to regulate hunting by both tribal members and nonmembers on their reservations. The guidelines include possibilities for: (1) On-reservation hunting by both tribal members and nonmembers, with hunting by nontribal members on some reservations to take place within Federal frameworks but on dates different from those selected by the surrounding State(s); (2) on-reservation hunting by tribal members only, outside of usual Federal frameworks for season dates and length, and for daily bag and possession limits; and (3) off-reservation hunting by tribal members on ceded lands, outside of usual framework dates and season length, with some added flexibility in daily bag and possession limits. In all cases, the regulations established under the guidelines would have to be consistent with the March 10-September 1 closed season mandated by the 1916 Migratory Bird Treaty with Canada.

Tribes that desired special hunting regulations in the 1992-93 hunting season were requested in the May 8, 1992, Federal Register (57 FR 19883) to submit a proposal that included details on: (1) Requested season dates and other regulations to be observed; (2) harvest anticipated under the requested regulations; (3) methods that will be employed to measure or monitor harvest; (4) steps that will be taken to limit level of harvest, where it could be shown that failure to limit such harvest would impact seriously on the migratory bird resource; and (5) tribal capabilities to establish and enforce migratory bird hunting regulations. No action is required if a tribe wishes to observe the hunting regulations that are established by the State(s) in which an Indian reservation is located. The guidelines have been used successfully since the 1985-86 hunting season, and they were made final beginning with the 1988-89 hunting season (August 18, 1988; 53 FR 31612).

Although the August 7, 1992, proposed rule includes generalized regulations for both early and late season hunting, this rulemaking addresses only the early season proposals. Late season hunting will be addressed in the rulemaking to follow in September, 1992. As a general rule, early seasons begin during September each year and have a primary emphasis on such species as mourning and white-winged dove. Late

seasons are those that begin October 1 or later each year and have a primary emphasis on waterfowl.

Also, in the August 7, 1992, proposed rule, the Service pointed out that duck hunting regulations likely would have to continue to be restrictive because of the possibility of little overall improvement in the duck population status from last year. Hunting regulations were restrictive last year for the same reason. Recently completed production surveys on the breeding ground and the projected fall flight forecast indicate that the continental fall flight of ducks in 1992, statistically, is unchanged from the low level of last year (62 million vs. 61 million in 1992 and 1991, respectively). Although they have not been fully established as yet, late season duck hunting regulations will be somewhat restrictive again during the 1992-93 hunting season.

Comments and Issues Concerning Tribal Proposals

For the 1992-93 migratory bird hunting season, the Service received requests from eleven tribes and/or Indian groups that followed the June 4, 1985, guidelines and are appropriate for final rulemaking. This is one less than the number cited in the proposed rule; one tribe failed to provide supporting information for its informal proposal. Some of the proposals submitted by the tribes have both early and late season elements. However, as noted earlier, only those with early season proposals are included in this final rulemaking; six tribes have proposals with early seasons.

Comments and revised proposals received to date are addressed in the following section. The comment period for the proposed rule, published on August 7, closed on August 24, 1992. Because of the brief comment period that was necessary, any comments received on the proposed rule and/or these early season regulations not responded to herein will be addressed in the late season final rule to be published in September.

Great Lakes Indian Fish and Wildlife Commission, Odanah, Wisconsin

In a July 9, 1992, letter to the Great Lakes Indian Fish and Wildlife Commission (GLIFWC), copied to the Service, the State of Wisconsin Department of Natural Resources (WDNR), voiced an overall nonobjection to the regulations then proposed by the GLIFWC for hunting by Chippewa tribal members. With regard to the opening dates of the duck and goose seasons, the WDNR had no

objection at that time to the GLIFWC proposal. However, the WIDNR reserved the right to modify its position pending further development of 1992 waterfowl production and fall flight forecast information. The WIDNR requested further that tribal members honor the noon opening of the State's shooting hours regulations for the first day of the duck season opening, and comply with Wisconsin's open-water restrictions. In addition, the WIDNR noted that the GLIFWC proposed earlier opening for woodcock is consistent with Federal frameworks.

In an August 7, 1992, FAX to the Service, the GLIFWC further defined their proposed duck hunting regulations for the 1992-93 season, as they had pledged to do as more information became available on 1992 duck populations. The revised GLIFWC proposal differs from the original only in respect to duck bag limits, and leaves intact season dates given in the proposed rule. The communication from GLIFWC states in relevant part:

"The tribes propose an unlimited daily limit including no more than 5 mallards, 3 wood ducks, 1 black duck, 1 redhead and 1 pintail. The season on canvasbacks remains closed * * *

"On reviewing the proposed tribal regulations, please consider the following. The tribes are as concerned about resource protection as the U.S. Fish and Wildlife Service. Harvest regulations and projects aimed at protecting or enhancing waterfowl habitat are but two examples of how this concern is manifested by the tribes.

"In addition, tribal members hunt primarily for subsistence rather than sport. A subsistence waterfowl harvest might also be described as 'opportunistic,' with members harvesting waterfowl for food when the birds are available and in as short a period of time as possible. In order to provide tribal members with a subsistence hunt, liberal bag limits have been proposed. However, bag limits for species exhibiting low population levels have been maintained.

"Furthermore, these proposed regulations should be considered in light of the level of tribal waterfowl harvest during the past years (see attached report). The number of waterfowl taken has ranged from 336 to 1478.

"This compares to approximately 62,000 waterfowl harvested by state hunters in the Wisconsin Ceded Territory. The tribal waterfowl harvest represents 0.5% to 2.3% of the state harvest in the Ceded Territory."

The Service's response is that under any but the most extraordinary circumstances a request for an unlimited

bag limit for any species or group of species is unacceptable because it is not consistent with sound wildlife management principles. Thus, given the continuing depressed state of continental duck populations, such a request appears not to be appropriate—irrespective of harvest regulations and/or habitat projects for enhancement and protection. As stated earlier, statistically speaking, the 1992 fall flight forecast of 62 million birds is not an improvement over the low figure of 61 million birds for the 1991 season. In fact, the 1991 continental duck fall flight was essentially unchanged from that of 1990. Yet in the 1991-92 season the Service acknowledged the need and concurred with the request by the GLIFWC for an additional duck in the daily bag, and 2 in the possession limit bag. The 1-duck increase approval was based at that time on a jurisdiction to realize a subsistence harvest for tribal members and a modest production increase in strictly local birds. In consideration of all the pertinent factors, including those outlined above, the Service is denying the request for an unlimited daily bag limit for the GLIFWC. The Service will hold the bag limit for GLIFWC for the 1992-93 season at the 1991-92 season level, with special limits on certain species, until such time as the overall duck population situation improves and/or a biologically appropriate request for bag limit change can be entertained.

The Service has received no communication from the State of Wisconsin regarding the revised GLIFWC proposal; the recency of the revision may have precluded a response.

In an August 24, 1992, letter, the Michigan Department of Natural Resources (MDNR) reiterated their objection to the Service's recognition of a Michigan 1836 Treaty Zone for regulations purposes and also objected to an unlimited duck limit in the Minnesota/Wisconsin Zone requested by the GLIFWC. Discussion of the June 2, 1992, letter from the MDNR, regarding Service recognition of the GLIFWC 1836 Treaty area, can be found in the August 7 proposed rule; the August 7 service response also covers the more recent August 24 letter. The matter of the request for an increased bag limit by the GLIFWC is discussed earlier in this document.

The Service has received no oral or written communications from the State of Minnesota regarding either the original or revised GLIFWC proposals.

Other Tribal Regulatory Proposals and Contacts

Discussion of the June 1, 1992, letter to the Service from the Arizona Game and

Fish Department concerning last year's regulations for the White Mountain Apache Tribe can be found in the August 7 proposed rule (57 FR 35452). In an August 24, 1992, letter to the Service, the White Mountain Apache Tribe revised their dove season dates to be in compliance with the early season framework for Arizona.

In their May 26, 1992, proposed regulations letter to the Service, the Confederated Salish and Kootenai Tribes advised that they and the State of Montana signed a comprehensive long-term (4-year) agreement in 1990 that enables all hunters to utilize waterfowl hunting opportunities on the Reservation. On June 2, 1992, the Service forwarded to the Mille Lacs Band of Chippewa a completed agreement with the Service regarding migratory bird management and hunting by tribal members on tribal lands for the 1992-93 season. The Service continues to seek further dialogue with the other tribes, i.e., the Klamath Tribe (Oregon), the Hoopa Valley Tribe (CA) and the Seminole Tribe of Florida, regarding the guidelines and future participation in the migratory bird harvest regulations process. As reflected in the proposed rule, the Service would like to work toward establishing migratory bird hunting regulations with other tribal groups that have an interest in cooperating on behalf of sound migratory gamebird management.

In summary, this rule amends § 20.110 of 50 CFR to make current for the early 1992-93 migratory bird hunting season the regulations that will apply on Federal Indian reservations, off-reservation trust lands and ceded lands. These regulations take into account the need to continue the reduced harvest of ducks.

Administrative Actions

NEPA Consideration

Pursuant to the requirements of section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(C)), the "Final Environmental Statement for the Issuance of Annual Regulations Permitting the Sport Hunting of Migratory Birds (FES-75-74)" was filed with the Council on Environmental Quality on June 6, 1975, and notice of availability was published in the *Federal Register* on June 13, 1975 (40 FR 25241). A supplement to the final environmental statement, the "Final Supplemental Environmental Impact Statement: Issuance of Annual Regulations Permitting the Sport Hunting of Migratory Birds (SEIS 88-

14) was filed on June 9, 1988, and a notice of availability was published in the *Federal Register* on June 16, 1988 (53 FR 22582), and June 17, 1988 (53 FR 22727). In addition, an August 1985 environmental assessment titled "Guidelines for Migratory Bird Hunting Regulations on Federal Indian Reservations and Ceded Lands" is available from the Service.

Nontoxic Shot Regulations

On May 13, 1991 (56 FR 22100), the Service published the final rulemaking on nontoxic shot zoning for the 1991-92 hunting season and future years. This rule, titled "Nationwide Requirement to Use Nontoxic Shot for the Taking of Waterfowl, Coots and Certain Other Species Beginning in the 1991-92 Season" provides that all of the waterfowl harvest beginning in that year will occur in nontoxic shot zones. This final rule also reminded hunters that nontoxic shot use is required in all U.S. offshore territorial waters and for the taking of captive-reared mallards on shooting preserves, in field trails and for bona fide dog training activities. All of the final hunting regulations covered by this rulemaking are in compliance with the Service's nontoxic shot requirements.

Endangered Species Act Consideration

Section 7 of the Endangered Species Act provides that, "The Secretary shall review other programs administered by him and utilize such programs in furtherance of the purposes of this Act" (and shall "insure that any action authorized, funded or carried out * * * is not likely to jeopardize the continued existence of any endangered species or threatened species or result in the destruction or adverse modification of (critical) habitat * * *"). Consequently, the Service has initiated section 7 consultation under the Endangered Species Act for the 1992-93 migratory bird hunting season regulations, which includes those that apply on Federal Indian reservations and ceded lands.

In a July 2, 1992, biological opinion, the Division of Endangered Species advised the Office of Migratory Bird Management of its conclusions that the proposed action is not likely to jeopardize either listed species or critical habitat. The Service's biological opinions resulting from its consultation under section 7 of the Endangered Species Act may be inspected by the public in either the Division of Endangered Species or the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, room 634-Arlington Square Building, 4401 N.

Fairfax Drive, Arlington, VA, or write Director/MBMO, U.S. Fish and Wildlife Service, 634 ARLSQ, Main Interior Building, Washington, DC 20240.

Regulatory Flexibility Act, Executive Orders 12291, 12612, and 12630, the Civil Justice Reform Executive Order (Executive Order 12778) and the Paperwork Reduction Act

In the May 8, 1992 *Federal Register* (57 FR 19865), the Service reported measures it had undertaken to comply with requirements of the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 *et seq.*) and Executive Order 12291, "Federal Regulation," of February 17, 1981. These included preparing a Determination of Effects and revising the Final Regulatory Impact Analysis, and publication of a summary of the latter. These regulations have been determined to be major under Executive Order 12291, and they have a significant economic impact on substantial numbers of small entities under the Regulatory Flexibility Act. It has been determined that this rule will not involve the taking of any property rights, as defined in Executive Order 12630, and will not have any significant federalism effects, under Executive Order 12612. These determinations are detailed in the aforementioned documents which, with other documentation, are available on request from the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Room 634-Arlington Square, Washington, DC 20240. The Department of the Interior has certified to the Office of Management and Budget that these proposed regulations meet the applicable standards provided in sections 2(a) and 2(b)(2) of Executive Order 12778. These regulations contain no collection of information subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*)

Memorandum of Law

The Service's Memorandum of Law, required by Section 4 of Executive Order 12291, was published in the *Federal Register* on August 21, 1992 (57 FR 38202).

Authorship

The primary author of this early season final rule is Dr. Keith A. Morehouse, Office of Migratory Bird Management, working under the direction of Thomas J. Dwyer, Chief.

Regulations Promulgation

The rulemaking process for migratory bird hunting must, by its nature, operate under severe time constraints. However,

the Service is of the view that every attempt should be made to give the public the greatest possible opportunity to comment on the regulations. Thus, when the proposed hunting regulations for certain tribes were published on August 7, 1992, the Service established the longest possible period for public comments. In doing this, the Service recognized that time would be of the essence. However, the comment period provided the maximum amount of time possible while ensuring that this final rule would be published before the beginning of the early hunting season beginning on September 1, 1992.

Under the authority of the Migratory Bird Treaty Act of July 3, 1918, as amended (40 Stat. 755; 16 U.S.C. 703 *et seq.*), the Service prescribes final hunting regulations for certain tribes on Federal Indian reservations (including off-reservation trust lands) and ceded lands. The regulations specify the species to be hunted and establish season dates, bag and possession limits, season length, and shooting hours for migratory game birds other than waterfowl.

Therefore, for the reasons set out above, the Service finds that "good cause" exists, within the terms of 5 U.S.C. 553(d)(3) of the Administrative Procedure Act, and this final rule will take effect on September 1, 1992.

List of Subjects in 50 CFR Part 20

Exports, Hunting, Imports, Reporting and recordkeeping requirements, Transportation, Wildlife.

Accordingly, part 20, subchapter B, chapter I of title 50 of the Code of Federal Regulations is amended as follows:

PART 20—[AMENDED]

1. The authority citation for part 20 continues to read as follows:

Authority: Migratory Bird Treaty Act, as amended (16 U.S.C. 703 *et seq.*). (Editorial Note: The following hunting regulations provided for by § 20.110 of 50 CFR part 20 will not appear in the Code of Federal Regulations because of their seasonal nature).

2. Section 20.110 is revised to read as follows:

§ 20.110 Seasons, limits and other regulations for certain Federal Indian reservations, Indian Territory, and ceded lands.

(a) Great Lakes Indian Fish and Wildlife Commission, Odanah, Wisconsin (Tribal Members Only).

Ducks.

Wisconsin and Minnesota Zones:

Season Dates: Open September 21, close November 1, 1992.

Daily Bag Limit: The daily bag limit is 4, including no more than: 1 hen mallard and 3 mallards total; 3 wood ducks; 1 black duck; 1 redhead and 1 pintail. The taking of canvasbacks is prohibited.

Mergansers.

Wisconsin and Minnesota Zones:
Season Dates: Open September 21, close November 1, 1992.

Daily Bag Limit: The daily bag limit is 5, including no more than 1 hooded merganser.

Canada Geese.

Wisconsin and Minnesota Zones:
Season Dates: Open September 14, close December 1, 1992.

Daily Bag Limit: The daily bag limit is 5.

Michigan, 1842 Treaty Zone:
Season Dates: Open September 1, close September 10, 1992.

Daily Bag Limit: The daily bag limit is 5.

Michigan, 1836 Treaty Zone:
Season Dates: Open September 1, close September 10, 1992.

Daily Bag Limit: The daily bag limit is 5.

Other Geese (Blue, Snow, and White-fronted).

Wisconsin and Minnesota Zones:
Season Dates: Open September 14, close December 1, 1992.

Daily Bag Limit: The daily bag limit is 7 minus the number of Canada geese taken, including no more than 2 white-fronted geese.

Coots and Common Moorhens (Gallinule).

Wisconsin and Minnesota Zones:
Season Dates: Open September 21, close November 1, 1992.

Daily Bag Limit: The daily bag limit is 20, singly or in the aggregate.

Sora and Virginia Rails.

Wisconsin and Minnesota Zones:
Season Dates: Open September 21, close November 1, 1992.

Daily Bag Limit: The daily bag limit is 25, singly or in the aggregate. The possession limit is 25.

Michigan, 1842 and 1836 Zones:
Season Dates: Open September 15, close November 14, 1992.

Daily Bag and Possession Limits: The daily bag limit is 25, singly or in aggregate. The possession limit is 25.

Common Snipe.

Wisconsin and Minnesota Zones:
Season Dates: Open September 21, close November 1, 1992.

Daily Bag Limit: The daily bag limit is 8.

Michigan, 1842 and 1836 Zones:
Season Dates: Open September 15, close November 14, 1992.

Daily Bag Limit: The daily bag limit is 8.

Woodcock.

Wisconsin and Minnesota Zones:
Season Dates: Open September 8, close November 30, 1992.

Daily Bag Limit: The daily bag limit is 5.

Michigan, 1842 and 1836 Zones:
Season Dates: Open September 15, close November 14, 1992.

Daily Bag Limit: The daily bag limit is 5.

General Conditions: (i) While hunting waterfowl, a tribal member must carry on his/her person a valid tribal waterfowl hunting permit.

(ii) Except as otherwise noted, tribal members will be required to comply with tribal codes that will be no less restrictive than the provisions of Chapter 10 of the Model Off-Reservation Code. This Model Code was the subject of the stipulation in *Lac Courte Oreilles v. State of Wisconsin* regarding migratory bird hunting. Except as modified herein, these amended regulations parallel Federal requirements, 50 CFR part 20, and shooting hour regulations in 50 CFR part 20, subpart K, as to hunting methods, transportation, sale, exportation and other conditions generally applicable to migratory bird hunting.

(iii) Tribal members in each zone will comply with State regulations providing for closed and restricted waterfowl hunting areas.

(iv) Minnesota and Michigan—Duck Blinds and Decoys. Tribal members hunting in Minnesota will comply with tribal codes that contain provisions parallel to M. S. 100.29, Subd. 18 (duck blinds and decoys). Tribal members hunting in Michigan will comply with tribal codes that contain provisions parallel to Michigan law regarding duck blinds and decoys.

(v) Possession limits for each species are double the daily bag limit, except on the opening day of the season, when the possession limit equals the daily bag limit, unless otherwise specified.

(vi) Possession limits are applicable only to transportation and do not include birds which are cleaned, dressed, and at a member's primary residence. For purposes of enforcing bag and possession limits, all migratory birds in the possession or custody of tribal members on ceded lands will be considered to have been taken on those

lands unless tagged by a tribal or State conservation warden as having been taken on-reservation. In Wisconsin, such tagging will comply with Sec. NR 19.12, Wis. Adm. Code. All migratory birds which fall on reservation lands will not count as part of any off-reservation bag or possession limit.

(b) *Oneida Tribe of Indians of Wisconsin, Oneida, Wisconsin (Tribal Members).*

Geese

Season Dates: Open September 1, close November 11, 1992.

Daily Bag and Possession Limits: Daily bag limit is two (2) tribally tagged Canada geese. The tribe will reissue tags as each 2 birds are registered. A season quota of 150 birds is adopted. If the quota is reached before the season concludes, the season will be closed at that time.

(c) *Navajo Indian Reservation, Window Rock, Arizona (Tribal Members and Nonmembers).*

Band-tailed Pigeons

Season Dates: Open September 1, close September 30, 1992.

Daily Bag and Possession Limits: The daily bag limit is 5 and the possession limit is 10.

Mourning Doves.

Season Dates: Open September 1, close September 30, 1992.

Daily Bag and Possession Limits: The daily bag limit is 10 and the possession limit is 20.

General Conditions: Tribal and nontribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR part 20, regarding shooting hours and manner of taking. In addition, each waterfowl hunter 16 years of age or over must carry on his/her person a valid Migratory Bird Hunting and Conservation Stamp (Duck Stamp) signed in ink across the face. Special regulations established by the Navajo Nation also apply on the reservation.

(d) *Penobscot Indian Nation, Old Town, Maine (Tribal Members Sustenance Season).*

Ducks.

Season Dates: Begin September 19, close November 30, 1992.

Daily Bag Limits: The daily bag limit is 4, except that it may include no more than 1 black duck and 2 wood ducks.

Geese.

Season Dates: Begin September 19, close November 30, 1992.

Daily Bag Limits: The daily bag limit is 3 Canada geese, 3 snow geese, or 3 geese in the aggregate.

General Conditions: (i) Tribal members may hunt waterfowl (ducks and geese) on Penobscot Indian Territory under special sustenance regulations during the 1992-93 hunting season. When the sustenance and Maine's general waterfowl season overlap, the daily bag limit for tribal members is only the larger of the two daily bag limits.

(ii) Possession limits on ducks and geese during the tribal sustenance season are applicable only to transportation and do not include birds which are cleaned, dressed, and at a member's residence.

(iii) Tribal members shall comply with all other basic Federal migratory bird hunting regulations in 50 CFR part 20, except that when sustenance hunting tribal members shall be permitted to hunt one-half hour before sunrise to one-half after sunset.

(iv) Each tribal waterfowl hunter 16 years of age or over must possess and carry on his/her person a valid Migratory Bird Hunting and Conservation Stamp (Duck Stamp), signed in ink across the face.

(v) Special regulations established by the Penobscot Indian Nation also apply in Penobscot Indian Territory.

(e) *Tulalip Tribes of Washington, Tulalip Indian Reservation, Marysville, Washington (Tribal Members).*

Ducks/Coot.

Season Dates: Open September 1, 1992, and close February 1, 1993.

Daily Bag and Possession Limits: The daily bag limit is 6, with 12 in possession; except that bag and possession limits are restricted for pintail (1) and canvasback/redhead (2 of either or 1 each).

Geese.

Season Dates: Open September 1, 1992, and close February 1, 1993.

Daily Bag and Possession Limits: The daily bag limit is 6, with 12 in possession; except that the bag limits for brant and cackling and dusky Canada geese are to be those established for the State of Washington in accordance with final Federal frameworks, to be announced.

Snipe.

Season Dates: Open September 1, 1992, and close February 1, 1993.

Daily Bag and Possession Limits: The daily bag limit is 6, with 12 in possession.

General Conditions: All hunters are required to adhere to shooting hour regulations of one-half hour before sunrise to sunset, and a number of other special regulations enforced by the tribes and available at the tribal office.

(f) *Fort Apache Indian Reservation, Whiteriver, Arizona (Tribal Members and Nonmembers).*

Band-tailed Pigeons.

Season Dates: Open September 1, close September 30, 1992.

Daily Bag and Possession Limits: The daily bag limit is 5 and the possession limit is 10.

Mourning Doves.

Season Dates: Open September 1, close September 15, 1992.

Daily Bag and Possession Limits: The daily bag limit is 10 and the possession limit is 20.

General Conditions: All non-tribal hunters hunting band-tailed pigeons and mourning doves on Reservation lands shall have in their possession a valid White Mountain Apache Daily or Yearly Small Game Permit. In addition to a small game permit, all non-tribal hunters hunting band-tailed pigeons must have in their possession a White Mountain Special Bank-tailed Pigeon Permit. Other special regulations established by the White Mountain Apache Tribe apply on the reservation. Tribal and nontribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR part 20 regarding shooting hours and manner of taking.

Dated: August 26, 1992.

Bruce Blanchard,

Director, Fish and Wildlife Service.

[FR Doc. 92-20893 Filed 8-31-92; 8:45 am]

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**REGISTERED
PARTIAL
RENTAL**

Tuesday
September 1, 1992

Part VI

**Department of
Housing and Urban
Development**

Office of the Secretary

24 CFR Parts 91 and 570
Comprehensive Housing Affordability
Strategies; Final Rule

DEPARTMENT OF HOUSING AND
URBAN DEVELOPMENT

Office of the Secretary

24 CFR Parts 91 and 570

[Docket No. R-92-1507; FR-2932-F-06]

RIN 2501-AB13

Comprehensive Housing Affordability
Strategies

AGENCY: Office of the Secretary, HUD.

ACTION: Final rule.

SUMMARY: This final rule revises an interim rule now in effect with respect to the Comprehensive Housing Affordability Strategy (CHAS) document to be prepared and submitted to HUD as part of the planning process for a jurisdiction with respect to HUD programs and other resources related to affordable housing and supportive services. The interim rule, published on February 4, 1991 (56 FR 4480), has been the subject of considerable public comment, especially since the jurisdictions have had experience with the CHAS procedure in the Fall of 1991. This rule responds to those comments. It provides guidance to be followed in the preparation of the annual plans and for submission of a complete CHAS.

EFFECTIVE DATE: October 1, 1992.**FOR FURTHER INFORMATION CONTACT:**

Mary Kolesar, Director, Program Policy Division, Office of Affordable Housing Programs, Office of Community Planning and Development, 451 Seventh Street, SW., Washington, DC 20410, telephone (202) 708-2470 or (202) 708-2565 (TDD).

SUPPLEMENTARY INFORMATION: This preamble is organized in the following outline:

- I. Information Collections
- II. Background
- III. Revised CHAS
 - A. Community Profile
 - B. Five-year Strategy
 - C. One-year Action Plan (Annual Plan)
 - D. Changes from Interim Rule
- IV. Comments and Responses
 - A. Overview
 - B. Organization of CHAS
 - C. Focus of CHAS
 - D. Data Collection
 - 1. Burden of Collection
 - 2. Excessive Data Collection
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 - 4. Sources of Data
 - E. Definitions
 - F. Coordination of State and Local CHASs
 - 1. Incorporation
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 - G. Consultation with Social Service Agencies
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- J. Public Housing
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- L. Institutional Structure
- M. Court Orders and Consent Decrees
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- O. Certifications
 - 1. Fair Housing
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- P. Citizen Participation
 - 1. General
 - 2. Public Hearings
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 - 4. Publicity
 - 5. Access to Records
 - 6. Summary of Citizen Comments
 - 7. Resolution of Citizen Complaints
- Q. CHAS Submission and Review
 - 1. Submission of Housing Strategy
 - 2. Approval of Housing Strategy
 - 3. Amendment and Resubmission of Housing Strategy
- R. Performance Reports and Reviews
- S. Miscellaneous
 - 1. Abbreviated Strategy
 - 2. Special Cases
 - 3. Waiver Authority
- V. Findings and Certifications
 - A. Environmental Review
 - B. Impact on the Economy
 - C. Federalism Impact
 - D. Impact on the Family
 - E. Regulatory Agenda
 - F. Impact on Small Entities
 - G. Public Reporting Burden

I. Information Collections

The information collection requirements contained in §§ 91.17, 91.19, 91.21, 91.23, 91.25, 91.40, 91.42, 91.44, 91.46, 91.48, 91.60, 91.62, 91.63, 91.68, 91.70, 91.78 and 91.82 of this rule have been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1980 (44 U.S.C. 3504(h)). No person may be subjected to a penalty for failure to comply with these information collection requirements until they have been approved and assigned an OMB control number. The OMB control number, when assigned, will be announced by separate notice in the Federal Register.

Public reporting burden for the collection of information requirements contained in this rule are estimated to include the time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Information on the estimated public reporting burden is provided in paragraph IV.G. of this preamble.

Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, should be sent to the Department of Housing and Urban Development, Rules Docket Clerk, 451 Seventh Street SW,

Washington, DC 20410-0500; and to the Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 3001, Washington, DC 20503, Attention: Desk Officer for HUD.

II. Background

The interim rule on the CHAS published last February was the foundation for forms and instructions made available to the jurisdictions in August of 1991. The public comments received on the CHAS included both comments on the rule and comments on the forms and instructions.

In addition to the interim rule, there were several other publications in the Federal Register concerning the CHAS. A final rule was published on October 31, 1991 (56 FR 56124), amending various program regulations that had referred to the planning documents that were superseded by the CHAS. A Notice was published on December 18, 1991 (56 FR 65271), giving instructions on how to prepare an abbreviated housing strategy. (The abbreviated strategy had received only cursory attention in the interim rule on the CHAS, and jurisdictions and HUD field offices had asked for more guidance in advance of a final rule for the following fiscal year.)

The initial comment period for the interim rule, announced in the rule, was February 4-May 6, 1991. The Department decided that, since the forms were not yet available and jurisdictions had not yet had experience under the interim rule, an additional comment period was needed. Therefore, a second comment period was announced in the Federal Register on August 12, 1991 to last through September 12, 1991. Since CHAS documents were due to HUD October 31, 1991, a third comment period was announced on October 1, 1991, to last through November 15, 1991.

In addition to written public comments, HUD received criticism and recommendations concerning both the rule and the forms in various meetings. The principal meeting was held on November 21, 1991 at HUD Headquarters in Washington, DC. The meeting was attended by representatives of city, county and State agencies, as well as associations representing the interests of States, real estate developers, low income housing providers, and manufactured housing developers, as well as homeless advocacy groups and a group concerned about lead-based paint. Minutes of that meeting were prepared and entered in the record of comments received.

III. Revised CHAS

The main changes to the CHAS rule have been made in response to public comments, which are described in more detail below. The structure of the rule has been changed to provide separate subparts for local governments and for States, so that the contents of the strategy of each can be described in more than one section. The contents of the strategy have been organized into three major components: Community (or State) profile, five-year strategy, and annual plan. This preamble discusses each of these major components, generally, and then discusses the main changes from the interim rule provisions.

The Department also must point out that, although this final rule, containing new requirements for the five-year strategy and the annual plan, is becoming effective during this fiscal year, the CHAS requirements that will actually affect jurisdictions this year will be those that deal with the annual plan, since a new five-year plan based on the 1990 Census data will not be due until the following fiscal year. The Department will furnish special instructions for this transition period. New Community Development Block Grant (CDBG) Entitlement grantees and new HOME Consortia submitting a CHAS for the first time in FY 93, will be required to submit a full five-year strategy this year. However, no needs or market inventory tables will be required of these jurisdictions.

A. Community Profile

In response to public comments, the community needs and resources descriptions have been organized in a community profile section, with important factors and trends to be discussed to enhance citizen understanding of the housing strategy. This section provides for a description of the significant housing and supportive housing market and inventory characteristics, factors affecting the availability of affordable and supportive housing, current and projected needs for housing assistance, and resources and programs expected to be available to address these identified needs.

B. Five-Year Strategy

In this section, the jurisdiction must describe its general priorities for allocating available Federal, State, local, and private resources over the five-year period among different needs and activities and among geographic areas. The description must include an analysis of how the size, distribution, condition, and cost of the jurisdiction's

housing inventory matches the severity of needs and types of housing problems of each priority category of residents. In addition, the jurisdiction must indicate the housing activities to be undertaken, e.g., acquisition, rehabilitation, new construction, rental assistance, homebuyer assistance, or support facilities and services, and the programs and resources it plans to pursue. The description must identify a relative priority of 1, 2, 3, or 0 (no priority) for the various categories of residents to be served. This narrative material will be supplemented by completion of a HUD-prescribed table. The planned geographic distribution of assistance will also be described, by whatever geographic breakdown seems useful to the jurisdiction.

Each priority will be the subject of a description of what is already being done to serve the target population and a strategy for accomplishing the goal.

C. One-Year Action Plan (Annual Plan)

This component specifies the jurisdiction's plan for use of affordable and supportive housing funds expected to be received during the Federal fiscal year. The narrative must discuss what is to be done to respond to the needs identified, particularly with respect to the highest priority categories. It will also discuss what actions are to be taken to resolve public policy issues, to overcome gaps in the institutional structure, to encourage public housing improvements (for local jurisdictions) and public housing resident initiatives, and to coordinate the Low-Income Housing Tax Credit with development of affordable housing (for States). In addition, the one-year action plan projects the number of families to be served during the year with either funds on hand or to be received during the year.

This component of the strategy also contains the certifications that the jurisdiction will affirmatively further fair housing and will comply with its residential displacement plan.

D. Changes From Interim Rule

There are five principal changes from the interim rule contained in this final rule: (1) The document has been reorganized and redundancies have been eliminated; (2) the data requirements have been streamlined, reducing the burden on States and localities; (3) the citizen participation process has been strengthened; (4) the rule reflects differences between States and local governments to the extent permitted by the statute; and (5) an explanation of the meaning of

"consistency with the CHAS" has been added.

1. Reorganization

The reorganization (discussed above, and at more length below) makes the document much more understandable to citizens and to the preparers.

2. Reduction of Data Requirements

The State is not required to present needs and market inventory data beyond that which is provided by HUD while the only data a local jurisdiction must gather itself is an assessment of housing conditions in the area. Otherwise, Census data may be relied upon. In several categories of data, information is only required to be provided to the extent it is available, such as for homeless subpopulations, for non-homeless persons with special needs, and for assessments of environmental concerns, such as lead-based hazard.

The elimination of the requirement to provide data separately for each racial and ethnic group by income category and tenure type reduces the burden on jurisdictions of all types. The interim rule also eliminates the requirement for separate data breakouts for CDBG entitlement communities and nonentitlement communities within the State, and for metropolitan/nonmetropolitan breakouts for each nonentitlement area of the State. Although the statute suggested categorization of data by metro/nonmetro areas, public response indicated that it would be too limiting to States, which might be using other geographic breakdowns for planning purposes.

3. Citizen Participation

The final rule strengthens this process by placing the public hearings at the beginning of the development process, focusing on needs. Although the minimum length of the citizen comment period on the draft CHAS has been shortened from 60 days to 30 days to accommodate the needs of jurisdictions, the rule adds suggestions for making citizen input on the CHAS more meaningful. Outreach to neighborhood organizations, advocacy groups, and social service organizations is encouraged.

4. Differences for States

States found the incorporation of local CHASs into State CHASs, encouraged in the interim rule, was unworkable (as discussed below in the public comment response). Therefore, it has been eliminated in this final rule. The assisted

housing inventory item for States has been limited to cover only State Housing Agency administered assisted housing.

5. Consistency With a CHAS

A section has been added to address the question of what it means for a jurisdiction to certify that an application for funding under a particular HUD program is consistent with its CHAS. This helps both jurisdictions and citizens affected by CHAS certifications understand the significance of the various elements of the document. The annual plan, which contains descriptions of the categories of residents to be served (including goals), specific activities to be undertaken, geographic allocation of resources, and service delivery systems for the jurisdiction's strategy, is the component of the CHAS against which the application should be measured in terms of the program, location, and beneficiaries. The five-year strategy is used to determine whether the activity serves a priority category of residents.

In addition, the rule tailors the statutory requirements to the unique circumstances of the District of Columbia—a city that the statute classifies as a State. The rule provides, in § 91.48, that the District of Columbia is to follow the CHAS requirements for local governments, with the addition of one of the requirements for States: A strategy to coordinate low-income housing tax credits.

IV. Comments and Responses

A. Overview

In response to publication of the CHAS interim rule and the issuance of forms and instructions, the Department received 190 comments from States, localities, intergovernmental organizations, public interest groups, community organizations, private firms, professional associations, universities, Congressmen, and concerned citizens. The overall thrust of the comments was very supportive of the concept of the CHAS—a well reasoned, action-oriented planning and management tool leading to realistic strategies intended to meet the affordable housing needs identified within each jurisdiction. However, there were numerous objections to provisions of the interim rule and instructions, as well.

Several commenters commended the CHAS process for providing a forum for housing planning and information exchange. Overall, they felt that the process is valuable, particularly due to the involvement of numerous housing and social service providers in determining priorities. For instance,

according to one commenter, the development of the Fiscal Year 1992 CHAS provided an excellent opportunity for Texas to initiate long-range planning for affordable housing. This CHAS represented Texas' first effort to address housing needs on a comprehensive, statewide basis. Six advocacy agencies praised the CHAS and CHAS process. Four of the six expressed their enthusiasm at being provided this "extraordinary opportunity" to improve housing programs across the country.

The Department believes that the CHAS process has strengthened Federal, State and local partnerships to meet the housing needs of low-income families, homeless and those needing supportive services. It is hoped that the annual process for preparing or updating the strategy will continue to provide a productive public forum.

However, some commenters criticized the lack of opportunity for public review of the rule before the regulations became effective, suggesting that the regulations should have taken the form of a proposed rule, not an interim rule. The Department had to prepare an interim rule rather than a proposed rule because of the statutory requirement that a jurisdiction must have an approved CHAS before it could receive either CDBG or HOME funds. This final rule does take into account the significant public comment that has been received, making major revisions as a result.

One commenter called for greater emphasis in the CHAS on targeting limited resources to those most in need. The Department has responded to the comments requesting greater targeting to those most in need and has required the needs, priorities, and goals be established for those below 30 percent of median income.

A commenter noted that section 106 of the National Affordable Housing Act of 1990 requires applications for housing assistance "to be accompanied by a certification by an appropriate State or local public official that the proposed housing activities are consistent with the housing strategy of the jurisdiction to be served." The commenter felt that "consistency" has not been defined and should be defined. We agree, and a section has been added to this rule, as described above.

The commenter suggested that the standards for determining consistency should be broad enough to allow a consistency determination if the proposed activity meets a need, goal or objective identified in the CHAS, involves a funding source identified in the CHAS, or is consistent with

information contained in the CHAS. The final rule is not so broad as this last item requested, but it is generally responsive to this commenter's request.

One commenter pointed out that States will have to certify that applications for HUD funds are consistent with the State CHAS. The commenter feels that additional suggestions on the minimal requirements of such a certification would be beneficial, along with ideas on how to establish procedures for applicants to obtain certifications. The new section on certification of consistency should be helpful. The procedure to be followed in obtaining such a certification will be determined by each State.

Three commenters commented on the monitoring requirements. One commenter requested that HUD provide guidance on developing local standards and procedures for monitoring. Another commenter suggested that HUD provide specific monitoring criteria and general reporting standards. One commenter recommended that HUD require jurisdictions to report on the results of their strategies, particularly with regard to homeless individuals. In § 91.85, the Department has outlined the issues it will review annually. However, the most important part of oversight of State and local housing strategies will be the citizen review of actual performance in meeting the priorities based on needs identified in the strategies.

Eight commenters objected to CHAS coverage of the Low-Income Housing Preservation Program, since funds are allocated directly to individual project sponsors, and not to local or State governments. The rule has been clarified to provide that only State agency administered preservation programs are covered by the CHAS requirements.

One commenter asked that the CHAS requirements be extended to include housing assistance programs other than those funded by HUD, such as the Low-Income Housing Tax Credit. Two commenters were concerned that major housing programs, such as Section 8 rental assistance, would not require a certification of compliance with an approved housing strategy. The rule simply reflects the statute in this respect—it cannot extend the applicability of CHAS requirements beyond the statutory mandate. However, the Low-Income Housing Tax Credit program is taken into consideration by jurisdictions in development of their CHASs.

(We note, however, that one component of the Section 8 program is subject to a certification of consistency with the CHAS—the Moderate

Rehabilitation Single Room Occupancy program, which is a program for homeless persons operated under the authority of the McKinney Homeless Assistance Act. There is also a link with the CHAS in the Section 8 Certificate program in that one basis for HUD approval of rents above Fair Market Rents is that implementation of the approved housing strategy for the area requires the higher rents.)

Clarification was requested by a commenter on whether the list of "Programs not covered" was all-inclusive, since programs such as the Congregate Housing Services Program and Hope for Elderly Independence (sections 802 and 803 of the National Affordable Housing Act—NAHA) are not mentioned either as being covered or not being covered. These two programs are not covered by the CHAS. The list of programs covered is all-inclusive, while the other is not intended to be.

One commenter asked for clarification regarding whether an environmental finding will be required for the CHAS and, if so, what type. The commenter suggested that the issue of environmental findings and review be addressed in the regulations. Environmental reviews are required when related to the release and use of HUD program dollars but are not required for the preparation of a housing strategy. (See §§ 50.19 and 50.20.)

B. Organization of the CHAS

Most comments concerning the organization of the CHAS were critical, finding it generally repetitive, overlapping, and lacking the normal sequence of a planning document. Others urged simplification and called for greater flexibility so as not to stifle creativity.

Among the recommendations made were to prepare a clear Table of Contents listing issues which must be addressed (others objected to a rigid structure claiming that it reduces creativity) and to simplify the numbering of sections, parts, and tables. In response to those comments, the Department has developed a table of contents which provides structure to the document and eliminates redundancy. As described above, the document will consist of three parts: I. Community (or State) Profile; II. Five-Year Strategy; and III. Annual Plan. In the CHAS instructions, all the tables have been renumbered to reflect this new organization.

Another recommendation was to allow States and localities to structure the document in any manner, so long as the required 15 elements of a CHAS are

addressed. It was suggested that a checklist or crosswalk (similar to one HUD developed for States submitting an exiting strategy) could be used to identify the sections in the document that address the 15 statutory elements. Two commenters said that if the State or Community Profile is to become the foundation upon which the strategy rests, then HUD must require that its tables be used, enforce its narrative instructions, and provide training to jurisdictions on how to analyze data.

These differing opinions are difficult to resolve, but the Department has decided to maintain its position of prescribing the general format for the CHAS. While the Department appreciates the need for State flexibility in meeting the CHAS requirements, it found that submissions providing crosswalks to other planning documents often did not address all statutory elements. The Department also found that these submissions often referred to documents that either were not included or were not relevant to the contents of the CHAS. Therefore, the Department is prescribing the format for the document. However, the format does provide some flexibility in the order of some of the elements. If a jurisdiction wants to address an element in a place other than that prescribed, it can change its location and provide a cross-reference to the altered location. As described, training will be provided next Spring.

Commenters suggested that the Department merge the "needs assessment" and "market conditions" in the first part, or move the market conditions to precede the needs assessment. We have responded to this suggestion by placing the market conditions, as part of the community profile, as the first element of the CHAS after the summary of the development process. However, these two sections may appear in the order the States and local governments deem most appropriate.

The Department was also asked to permit the discussion of relevant public policies, institutional structure, and resources to precede presentation of the priorities. Another commenter suggested that the use of resources be discussed in the context of the priorities. We have rearranged this material somewhat. Resources are now to be discussed in the first part, Community Profile, whereas the public policies, institutional structure and priorities are to be included in the second part, Five-year Strategy. However, in the second part, the final rule does provide for priorities to be the first focus, with the discussion of institutional structure and public policies to follow.

The suggestion was made that HUD reorganize and consolidate discussions (including current conditions, needs analysis and implementation plan) under the groups to be served. Several commenters believed that the structure of the CHAS under the interim rule fragmented information with respect to particular groups and discouraged citizen participation. In the priority analysis and strategy development section of the Five-year Strategy, a State and local jurisdiction must analyze each category of residents and determine whether or not it is a priority. For those determined to be a priority, a State or local jurisdiction must describe how it will use the resources identified to meet the needs of that priority group.

Commenters suggested that HUD prepare and distribute a summary of available housing resources to include eligible uses and applicants. The Department will provide this information for Federally-assisted housing resources, and it is to be included in the CHAS so that citizens may have it when evaluating how well the strategy meets identified needs.

A new section that would restate the various action steps to be taken under the CHAS was also requested. In the Five-year Strategy, States and local governments are encouraged to provide a summary of their five year plan to provide the nexus between the needs identified and the actions and resources they plan to employ to address these needs. More than 80 percent of those State and local preparers contacted (10 States and 46 cities) had either prepared or endorsed the preparation of a summary, citing its importance as a link between identified needs and the priorities for action as well as its value for citizen review.

Among the other recommendations offered to improve the quality of the CHAS submissions was one that called for HUD to establish a clearinghouse so that jurisdictions with limited planning capabilities could obtain copies of exemplary housing strategies. The Department will establish a clearinghouse, and the local HUD field office can be consulted for technical assistance. In addition, HUD plans to offer, in the Spring of 1993, a course in strategic planning in major cities throughout the country.

Another recommendation was to combine the CHAS regulation, notice, forms and instructions into a single comprehensive, thorough, and consistent set of materials. It is the Department's intent to provide a complete package of CHAS regulations, instructions and forms.

C. Focus of CHAS

Eighteen commenters suggested that the CHAS should require that the jurisdiction demonstrate through its plan that resources are being allocated in accordance with the greatest need, and that strategic priorities should favor families and individuals at or below fifty percent of median income with particular emphasis on those below thirty percent of median. In response to comments on greatest need, the Department has required separate discussions on needs, five-year strategy and one-year action plan goals for two very low-income categories: (1) 0 to 30 percent and (2) 31 to 50 percent of median family income.

Commenters suggested that there is no need for emphasis on income categories higher than 80 percent of median, since most housing assistance programs serve only those at 80 percent or below. The statute requires that information be provided concerning needs of "moderate-income" families. The Department has chosen 95 percent of median family income as the upper limit of the moderate-income category for this purpose, since that is the limit used in some other HUD programs, such as the section 235 homeownership and section 221(d)(3) BMIR rental programs.

Several commenters encouraged HUD to include the below 30 percent of median family income category in its 1990 census special tabs so that jurisdictions can choose to analyze that group without undue burden. Information on the below 30 percent of median family income group will be provided in the special reports to be prepared by HUD. Furthermore, separate narratives and tabular breakdowns on this group will be required in the CHAS, since they constitute the most distressed portion of the population and are most threatened with becoming homeless.

Four commenters were concerned that the additional federal housing funds being made available through HUD programs might simply be used as a substitute for State or local resources currently dedicated to housing. Consequently, they recommended that over the five-year period covered by the CHAS an analysis should be conducted of the extent to which federal funds are used to augment or replace currently planned State and local housing efforts. This analysis is needed, in the view of the commenters, to promote informed citizens review of the CHAS.

Requesting an analysis on the amount of HUD funds used in substitution for other State and local resources goes beyond the statutory requirements for a

housing strategy. The Department has not included such a requirement.

Throughout the CHAS, HUD requires States and local governments to discuss unassisted low-income (and especially very low-income) families who pay more than 50% of their income for rent, live in substandard housing, or have been involuntarily displaced. Three advocacy agencies commented that they were pleased with HUD's emphasis on families experiencing "severe cost burden." The Department also received praise from five commenters for requiring information relating specifically to persons with disabilities.

Twelve commenters sought to require an allocation of resources proportionate to the needs identified in the particular jurisdiction while eight others would require jurisdictions to justify spending that was disproportionate to needs. In their view, mechanisms should be put in place to assure that funds distributed on a competitive basis are proportionate to need.

With regard to additional regulatory requirements on allocation of resources proportionate to needs, the Department has not adopted this recommendation. However, the Department believes that public review and comment on household review and comment on households served evaluated in the context of need is the most critical part of the citizen participation process.

Nine commenters favored a requirement for localities to identify any serious gaps in available private resources, such as long-term debt financing for small low-income projects, and to specify actions intended to bridge those gaps. As they discuss gaps in their delivery systems, State and local governments are free to discuss the absence of private financing for low-income housing and their strategies to secure additional funds.

Another commenter criticized the omission of any requirement to specify a baseline of the jurisdiction's activity to provide affordable housing. While jurisdictions are free to provide a history of their activities to serve low-income families, the homeless and other special needs population, the statute does not require a baseline of activity. Over time, the housing strategy and annual performance reports will provide level of effort information.

One commenter suggested that the CHAS should place more emphasis on energy conservation. The suggestion was made that, as a condition of approval, a jurisdiction be required to demonstrate in its CHAS that: (1) Its building code contains energy efficiency criteria at least as stringent as the 1989 Council of American Building Officials' Model Energy Code; (2) it has or will

establish energy efficiency guidelines for housing rehabilitation that meet HUD criteria for stringency and cost-effectiveness; (3) planning for the strategy directly involved energy organizations; (4) the planning process specifically sought funding from utility energy efficiency and public weatherization programs; and (5) it has articulated its affordable housing definition and program requirements to specifically encourage construction, rehabilitation or retrofit practices that strike a proper balance between initial cost and energy operating cost.

While the Department believes that the energy-related recommendations have merit they go beyond the statutory requirements of the CHAS.

*D. Data Collection**1. Burden of Collection*

Numerous commenters maintained that the time and cost of preparing the CHAS has been grossly underestimated for both localities and States in the interim rule. (HUD had estimated that producing the first CHAS would take 248 hours and subsequently require an additional 40 hours to produce performance review reports.) One State noted that the estimate was particularly low for States since they have so much territory to cover in order to solicit feedback from the public throughout the State as part of the citizen participation requirements. Regarding the cost of producing the CHAS, one State estimated that its CHAS preparation cost \$15,333 and one local government had spent \$11,300 at the time its comment was written but it had not yet completed its CHAS. One commenter recommended that the Department consult with State and local government agencies to develop more accurate estimates to be used in the final rule. In addressing the cost burden issue, one commenter recommended that HUD allow jurisdictions to exceed the cap on CDBG administrative costs or provide additional funds to States and localities for CHAS preparation.

The Department conducted an assessment of 46 local CHASs selected at random and consulted with their preparers, as well as with 10 State agencies, to get a better estimate of time and cost. Based on substantial reduction in the CHAS forms, the availability of 1990 Census data in the required format for the Fiscal Year 1994 complete submission, and the experience that States and local governments have gained to date, the Department believes its revised estimates are accurate reflections of the time required and the

costs to be incurred. The Department has now broken out the estimates separately for States and for localities, in recognition of the differences in their tasks.

2. Excessive Data Collection

Numerous commenters objected to the data collection requirements, contending that they exceeded the data collection authorized by NAHA and that the rule placed too much emphasis of data collection instead of on planning and strategy development. (It should be noted, however, that most of the specific examples cited were contained in the Paperwork Burden Submission to OMB published in the *Federal Register* on January 14, 1991, but removed before the publication of the interim rule.) This opinion was held, for the most part, by commenters representing States, localities, and their associations. On the other hand, many commenters stressed the importance of data collection, including racial, ethnic, and special need categories, and rued the lack of specific criteria by which the "validating" of strategies will be measured. These comments were made largely by representatives of public interest groups.

One commenter noted that the structural condition of housing, the extent of overcrowding, and cost burden of housing on families are not required by the statute. The information on the structural condition of housing, the extent of overcrowding, the cost burden of housing on families, occupancy status (i.e., occupied/vacant), and needs of special populations (e.g., elderly, disabled) constitute the very foundation for the development of any meaningful housing strategy, and requiring that such information be provided is firmly rooted in the statute. Moreover, HUD will supply the data on overcrowding, cost burden, and occupancy status. Information concerning special needs populations is required, to the extent it is available.

One commenter questioned how a city was to gather all the unit information and then categorize it as suitable for occupancy by elderly or disabled families and families with children, among others. The interim rule and the final rule request this information but do not require it, precisely because it may be difficult to obtain. However, through consultations with various social service agencies and nonprofit organizations seeking to serve these populations, a jurisdiction may become informed about units that would be suitable for them.

Of the eighteen comments received concerning racial/ethnic data, one commenter asked that HUD eliminate the requirement to identify and describe

neighborhoods with racial/ethnic concentrations, especially the requirement to identify specific locations. If eliminating the requirement is not possible, they requested that HUD simplify what must be presented in the CHAS document. One commenter said that it was not clear how the need for racial/ethnic group information results from the statutory requirements for the CHAS, and this information is not directly related to the strategy to be developed on the local level. Another commenter said that any housing policy that targets resources to racial/ethnic areas is questionable, since to do so could have the effect of promoting segregation.

The Department believes that the requirement to identify and describe neighborhoods with "racial/ethnic minority concentrations" is a key to evaluating how well State and local governments create housing opportunities both within and outside of areas of racial/ethnic concentrations, and therefore, the extent to which they are carrying out their promise to affirmatively further fair housing. The CHAS annual report requires jurisdictions to describe how they made housing resources more available both within and outside of these areas and the racial and ethnic status of those they served.

Other commenters objected to the inclusion of racial and ethnic data on the homeless, since it was not mentioned in the statute and does not seem useful or appropriate in developing a housing strategy. The Department believes that this information is useful in determining what groups may be most useful in providing supportive services (especially in the case of an ethnic group whose primary language is other than English). Therefore, the final rule requires the racial and ethnic composition of the homeless population to be discussed, to the extent that the information is available.

In recognition of the fact that States, in particular, may not have access to good data on their population in every respect, the data requirements for States have been significantly decreased in the final rule. For example, no information on structural condition is being required of States, and other requested information, such as cost burden and occupancy status, may be presented by those sub-State areas and regions determined by the State to be significant and meaningful to the development of a housing strategy and for which data is available from HUD.

For all HOME participating jurisdictions and CDBG entitlement communities, HUD will prepare special

reports on a state-by-state basis that provide the data needed to complete the needs, and market inventory and conditions tables in the CHAS, plus many more housing characteristics for each State, county, and city of 25,000 or more in the State. States and localities are encouraged to use this additional data in their analyses.

With respect to the State housing strategy, one commenter opposed the CHAS language calling for the disaggregation of statewide housing data by geographic regions on the basis that it exceeded the statute. Two States, among several commenters, felt that HUD's requirement that States break out data by entitled areas, non-entitled metropolitan areas and non-entitled non-metropolitan areas is inappropriate and cumbersome. They said it is difficult, awkward and time-consuming to look at State needs without the entitled areas. Both States recommended that aggregated metropolitan data and aggregated non-metropolitan data be used, instead of entitled/non-entitled metro and non-metro. Alternatively, it was recommended that States be able to define geographically similar sub-state divisions based on population density, economic patterns, housing conditions, and existing planning regions. One commenter pointed out that 91.20 of the interim rule provided latitude to States in the geographic presentation of data on housing needs, homeless assistance and market characteristics. Others pointed out that HUD's own data is collected on a county basis.

The Department agrees that the requirement that States break out data by entitled areas, non-entitled metropolitan areas and non-entitled non-metropolitan areas is cumbersome and may not be suitable for their purposes. Consequently, the final rule permits States to cover the whole State or those subareas that are most logical to them.

Another State protested the over-reliance on Census Data, which has only limited utility in many rural areas. This commenter called for greater flexibility by allowing States to develop appropriate indices of needs and markets. One commenter recommended that HUD should simply clarify for States what types of data are acceptable in the preparation of their strategies.

The final rule permits a State or locality to supplement Census data with other data obtained using HUD-approved methodologies. The rule also permits a State or locality to substitute data from a reliable source for Census data, if the jurisdiction describes the

source and the method used to generate the data. (See §§ 91.17(b) and 91.42(b).)

Two commenters called for cooperation between HUD and States having similar housing strategies already in place, such as California, on such matters as coordination of submission dates. Another contended that States which have put a great deal of effort into preparing housing plans not be penalized by having to rewrite these existing plans, but be allowed to use those strategies in their existing form.

It was the Department's experience in allowing the substitution of other planning documents for the CHAS, that information was incomplete, inadequate or irrelevant in meeting the statutory requirements of NAHA. Therefore, the final rule requires preparation of a CHAS, which may use much of the product of any State-created housing plan.

3. Insufficient Data Elements

Expansion of data presentation was urged by ten other commenters. They sought numbers on single parent households by gender, waiting lists for public and assisted housing, emergency or domestic violence shelter populations. Other commenters recommended that information requirements be expanded to include the rural housing needs of farm workers, adequacy of public assistance grants to pay for housing, the barriers to affordability that exist for people on welfare and those in transitional housing and the special needs of all persons with disabilities who are now homeless or who are at risk of becoming homeless. One citizen and three advocacy agencies urged HUD to require that housing and market conditions information be broken down by neighborhood within a jurisdiction, so that trends in the neighborhoods could be determined. Six commenters were of the opinion that information should be included on the number occupied "uninhabitable" units while seven wanted data on the number of "abandoned" units suitable for rehabilitation and affordable. Eight commenters also raised the need for estimating expected changes to the housing stock inventory over time due to such factors as demolition, conversion, and the expiration of tax exempt financing or other subsidies.

Seventeen commenters called for the Department to include an assessment of lead-based paint hazards in the CHAS requirements. These commenters felt that the CHAS is the appropriate vehicle for integrating the consideration of lead hazards into local housing decisions.

Their recommended changes would require CHASs to contain information on the presence of lead-based paint hazards in the local housing stock, including public housing, and would broaden the social service consultation requirement to include public health agencies. These commenters also called for inclusion in the CHAS of available information on the numbers of children already lead-poisoned including their home addresses.

Six commenters requested that the required data be expanded and elaborated upon to include estimates of the total number of homeless, including a breakdown by categories beyond those stated in the regulation (i.e., singles, families with children, veterans, persons with AIDS, elderly) and to provide more detail on the type of accommodations available at existing facilities. Eight advocacy agencies, one citizen and one local government commented in very strong terms about the need to require stricter reporting on homelessness in the CHAS. They argued that a housing strategy which does not document the problem and extent of homelessness cannot be the basis for a sound strategy to alleviate the problem. Several suggested that the CHAS instructions require documentation of the "at-risk" of being homeless population. Several commenters, however, deemed requirements such as attaching a list of all shelters and facilities for the homeless as "ridiculous".

Each of the recommended additions was considered, with the understanding that the CHAS rule and instructions represent the minimum information and discussion that is required of any jurisdiction in its CHAS submission. Jurisdictions may, and often do, exceed and expand upon the minimum requirements in order to better tailor the document to local housing conditions, needs, and circumstances. The existing CHAS rule and instructions do not prevent or exclude presentation of information or discussion relating to any particular category of residents or their housing needs. Upon consideration, however, it was decided to include a discussion of the jurisdiction's Section 8 and public housing waiting list(s), discussion of any anticipated loss of subsidized housing stock, and a broader discussion of a jurisdiction's homeless population, and to encourage a description of housing stock likely to contain lead-based paint hazard.

In the section of this rule on general market and inventory conditions, States and local governments are encouraged to provide, to the extent information is available, an assessment of the hazards

of housing-related environmental concerns, such as lead-based paint. Any plan to reduce such hazards should be included in any summary of the five-year strategy. Preparers are directed to consult community health organizations and census data on pre-1950 housing stock, which constitutes a satisfactory indicator of lead-based paint hazard for the purposes of the CHAS. (Data on pre-1978 housing is also useful, since that is the year in which the use of lead-based paint was discontinued throughout the country. However, the Department has found that use of lead-based paint was much more prevalent before 1950.) No special surveys are being required, and the Department will not require data on the numbers of lead-poisoned children or their home addresses.

The homeless table has been reinstated in the CHAS instructions, and required narratives remain at least as detailed. Jurisdictions may use 1990 Census data on homeless populations or any other source(s), such as social service providers, which they consider meeting the standards for accuracy and reliability that HUD specifies. HUD is making available to States and local jurisdictions a technical assistance resource Practical Methods for Counting Homeless People: A Manual for State and Local Jurisdictions, that is an easy to read compendium of techniques already being used by State and local governments to collect information on the extent and characteristics of homelessness. The Department sees value in the listing of shelters and facilities and has maintained that requirement.

Although housing and market conditions by neighborhood are not required by the statute or the rule, the Department will provide States and local governments 1990 Census data in a manner that would allow subsequent analysis. A jurisdiction may use this information to analyze trends in submarkets, such as neighborhoods. All jurisdictions, however, are expected to review and analyze this data in order to meet minimum tabular and narrative submission requirements.

4. Sources of Data

The issue of census versus alternative informational sources for the needs data was discussed by a number of commenters who essentially took the position that given that detailed population and housing census reports may not be available until 1993 and the 1990 data will become outdated, a greater reliance on locally generated "updated estimates" would seem to be called for. Consequently, they argued,

more explicit regulations describing the standards that HUD will use in accepting or rejecting these estimates are needed. Two commenters argued that if HUD provides relevant data in tabulated form and includes detailed instructions on how to use that data, the State or Community Profile section could become what it was meant to be. One commenter asked that HUD not require jurisdictions to submit data that goes beyond the scope of what was collected during the Census, but suggested that HUD accept additional data if a jurisdiction should opt to submit them. Other commenters suggested that required data be provided to States and cities in its final form.

In order to address the important issue of alternative data sources to the Census, HUD will prepare a handbook for jurisdictions on how to analyze a low-income housing market and will make recommendations on local sources of data and acceptable methodologies to be used. The handbook will also discuss State needs and data sources. It is understood that the need for reliable locally generated updates will increase over time.

E. Definitions

Several commenters requested that other terms be defined, including "habitability," "not substantially complete," "homeless family," "imminent danger of becoming homeless," and "primary nighttime residence." They felt that HUD should define these terms, or make reference to an existing definition, for the sake of consistency and to avoid requiring each locality to make up definitions.

The Department is not defining "habitability" but is asking local governments to characterize their housing stock as "standard" and "suitable for rehab" which are to be locally defined. The phrase "not substantially complete" refers to one of two bases for rejecting a housing strategy, and § 91.72 describes how that is defined. Section 91.5 defines "homeless family with children" and "homeless individuals." Instead of asking for information on those in "imminent danger of becoming homeless," the final rule requests information on "needs of persons threatened with homelessness," allowing jurisdictions to provide a definition but suggesting that those with incomes below 30 percent of median income would be most vulnerable. While the final rule does not define "primary nighttime residence," the CHAS instructions do define sheltered and unsheltered, which describe the

facilities under sheltered and the lack of appropriate facilities for unsheltered.

One commenter pointed out the HUD does not define concentrations of racial/ethnic minorities and low-income families. The Department has indicated in this final rule that the jurisdiction must state how it defines "area of racial/ethnic minority concentration" for purposes of describing its population characteristics. (See §§ 91.17(a)(1)(ii) and 91.42(a)(1)(ii).) The Department expects to publish a proposed rule for public comment on affirmatively furthering fair housing, which will include a definition of "area of minority concentration." Until public comment is obtained and a final rule is prepared, however, jurisdictions are to continue to define the concept.

Various commenters suggested changes or expanded language for several of the definitions given. A commenter objected to the definition of "overcrowding" because it might include common situations such as a mother and child living in a Single Room Occupancy unit. Since the Department will be providing 1990 Census data on overcrowding which uses the definition stated in the rule, this definition is preserved. Two commenters posited that the definition of "substantial amendment" was inadequate. Since it would be impossible for jurisdictions to anticipate all the programs that might eventually be applied for, an application for assistance through a program not specifically mentioned in the plan should not be considered as a "major change" requiring a "substantial amendment" to the strategy. The Department agrees with those concerned about the present definition of substantial amendment triggered by an application for a particular program. The term "substantial amendment" has been redefined to be a change to the five year strategy, which may be occasioned by a decision to undertake activities or programs that are inconsistent with the strategy. (See § 91.5.)

Finally, the suggestion was made by five commenters to substitute the term "persons with disabilities" for "those not capable of independent living" which was used in the interim rule, since it is more descriptive, easier to define, and less subjective. We have adopted the change.

F. Coordination of State and Local CHASs

1. Incorporation

Several commenters proposed that States no longer be given the option of incorporating local CHASs. It appeared to them that incorporation of local

CHASs poses an additional workload on States with only minimal benefit. One commenter voiced concern that a State would be penalized for the late or inadequate submission by a local government. The commenter went on to suggest that language be included to ensure that there would be no penalty for States which have demonstrated good faith efforts at coordination with local jurisdictions in preparing the CHAS.

On the other hand, one commenter expressed support for HUD's proposal to give States the option of incorporating local CHASs into their CHAS, or to cover those localities in their State CHAS. In order to permit incorporation, one commenter suggested that local CHASs be due three months before those of States so that States have an opportunity to truly review the local CHASs. One commenter expressed a concern that States in general do not necessarily consult with local governments on issues that touch those communities and, therefore, State strategies may not reflect local needs in a particular area or may in fact conflict with a local planning strategy and needs. This commenter recommended that States be required to incorporate the housing strategy prepared by a unit of local government for a particular area or explain why it does not.

The Department agrees that the requirement to incorporate local CHASs into the State CHAS was not worthwhile, in that it generated an additional workload on the State without corresponding benefit in the quality of the CHASs. However, States and units of local government are urged to cooperate in the identification of State-wide needs and the use of resources to meet those needs.

2. Mandatory Coordination

One commenter felt that the rule should be changed so that States and local governments are encouraged rather than required to coordinate their housing strategies. The rule has been revised to reflect this approach.

Six commenters suggested that the rule should be expanded to include a requirement that jurisdictions in the same Metropolitan Statistical Area coordinate their housing strategies. This section of the rule has been revised to encourage coordination among jurisdictions in the same metropolitan area.

G. Consultation with Social Service Agencies

Of the thirty-three commenters who responded to this topic, twenty-two

requested that HUD expand the consultation requirement to refer to various types of non-profit and social service agencies. Eight commenters believed that the requirement should be broadened to include public health agencies and that information on the number of children known to be lead poisoned be included where available. In addition, nine commenters recommended that the requirement be extended to include various types of voluntary, nonprofit housing and homeless assistance service providers (i.e., nonprofit housing developers, housing referral agencies, providers of homeless self-reliance program services). Nine commenters recommended that HUD require each jurisdiction preparing a CHAS to describe the "reasonable efforts" it has made to confer with social service agencies and certify to these efforts. Five commenters asked that the Department provide specific criteria that define the term "reasonable effort" in this section. One commenter suggested that the rule explicitly state that the purpose of the consultation requirement is for jurisdictions to gather input to help shape the CHAS, as opposed to an information gathering session for local officials.

The final rule includes a requirement that the jurisdiction include in its CHAS a summary of the development process, which describes the consultation with social service agencies serving the various populations in need. Beyond that, the citizen participation process and the requirement for a public hearing on needs should provide the means for extensive exchange and coordination among both public and private social service agencies. The Department believes that the State and local governments should be free to determine how this consultation takes place.

One commenter contended that the language in section 576 of the National Affordable Housing Act that requires consultation regarding the housing needs of foster care children in the development of the Housing Assistance Plan (HAP) also applies to the CHAS and should be included in the rule. The statute did not apply that consultation requirement to the CHAS, and so it is not included in this rule.

H. Resources

Two commenters responded to this section of the rule. One of the commenters believed that the phrase "where the State deems it appropriate" should be struck from this part so that all States would be required to include all Federally or State-owned land or property located in a geographic area

that may be used to carry out the purposes of the Act. The commenter claimed that this language provided a "large loophole" that allowed States to exclude certain suitable properties from consideration. This commenter also recommended that States be required to consider sources of non-Federal money that may be available to assist jurisdictions in nonmetropolitan areas in meeting match requirements of Federal programs. One commenter did not understand how States could be asked to indicate Federal funding going to the State months before Federal budgets are established. One commenter stressed that the plan for investment should be considered an estimate only since the actual distribution of funds depends upon the ability and number of applicants and the needs actually revealed by applications. This same commenter felt that States should only be required to include programs that they actually administer and that they should be permitted to show percentages rather than actual dollar amounts for the estimated allocation of funds under each program.

The Department believes that States are in the best position to determine the use of Federal and State land to meet the purposes of the Act. The language of the rule follows the statute in requiring the identification of publicly-owned land for affordable housing use—where the State deems it appropriate. The Department agrees with comments on the difficulty of forecasting the level and availability of Federal funds particularly for competitive programs. The Department will provide a listing of Federal resources available and requests that the State provide similar information on non-Federal and private sources for use in carrying out proposed activities.

I. Goals

Six of the eight commenters responding to the section on goals recommended that the language more clearly indicate that the goals must reflect the number of families assisted by all programs. These commenters also suggested that goals be established for both the one-year and five-year periods, and cover assistance provided with State, local or private funds where no Federal monies are involved. A commenter recommended that goals for investment and household assistance should be specified by program, suggesting then that progress could be measured on the basis of a specific program, rather than on goals that may cover two or more programs.

The goals are to reflect the number of households that have benefitted through

the investment of Federal funds (alone or in conjunction with other public or private funds) to provide housing that, at a minimum, satisfies HUD's housing quality standards for the Section 8 Housing Assistance Payments program. The Department believes that the development of a one-year investment plan naturally results in one-year goals, and that the development of goals for five years would be highly speculative. The Department has chosen not to request goals based on State or local funds, but State and local governments are free to provide more information than what is requested. Since two or more sources of funds may be used in a project, goals by program are not required.

Seven commenters wanted information displayed by the additional categories of race and ethnicity. While the goals are not broken down by race or ethnicity, the annual performance report statutorily requires such a breakdown for households served.

J. Public Hearing

Eighteen of the twenty-three commenters responding to the section requiring that a housing strategy include discussion of the public housing stock requested that language be added to require PHAs to cooperate in providing public housing information to the offices assigned the task of preparing the CHASs. The information should also include existing lead-based paint hazards, in their opinion. These commenters went on to propose that since jurisdictions may not have authority over PHAs or may not otherwise be able to ensure cooperation, the instructions in this section should be issued to all PHAs in the form of an amendment to the HUD handbook governing public housing management. The statute does not mandate PHA cooperation; however, the Department hopes that the CHAS is the product of cooperative efforts among all housing and social service agencies within the jurisdiction. The Department will consider providing management instructions to PHAs.

Four commenters urged that the information on public housing include the number of units available that are accessible and usable (or readily adaptable for use) by persons with disabilities. The accessibility issue with respect to public housing is addressed in the final rule (§ 91.17(a)(2)(ii)) by requiring information about accessible units and the need for modifying additional units. (Similar information is requested but not required with respect to other housing.)

One commenter sought to eliminate the language in the section of the strategy that leaves the impression that all PHAs are in need of improvements to management, operation, and the living conditions of residents, by adding the words "if appropriate" to the second sentence. The final rule preserves the language of the interim rule, because the statute requires the CHAS to include the PHA's strategy for such improvement.

One commenter objected to States having to include a description of the States' activities to encourage tenant management and ownership of public housing units, since States play a limited role in the operation of PHAs. The commenter noted that PHAs are subject to HUD review, and that HUD should exercise control directly. States are to discuss public housing resident initiatives only to the extent that a State housing authority or agency owns and manages public housing. This fact has been clarified in the final rule (§ 91.44(e)).

In the preamble of the interim rule, the Department mentioned the possibility of adding an element to the final rule requiring States to take a stronger role in preserving and improving the public housing stock. Five commenters responded, opposing such a requirement as exceeding the statute and as contrary to the intent of Congress. Commenters contended that such a requirement would add an unnecessary layer of bureaucracy to the operation of public housing and be overly burdensome to States. The final rule does not include this feature.

The Department received ten comments concerning public housing homeownership, eight of which suggested that language should be inserted to indicate that this section applies to jurisdictions only "if appropriate". Two commenters asked that HUD specifically mention in the rule that a jurisdiction's failure to convert public housing to private ownership would not affect CHAS approval. The rule reflects the statutory language concerning resident management and ownership. The failure to convert public housing to private ownership will not affect CHAS approval.

K. Public Policies

Twenty-two commenters responded with thirty-two comments to the section dealing with relevant public policies. Six of them recommended that State and local policies that promoted the preservation of affordable housing and prevented the displacement of very low-, other low-, and moderate-income families also be identified and included

along with those policies negatively affecting the availability of affordable housing. These same commenters called for the identification of public policies and efforts that expand housing opportunities for minorities outside of areas of minority concentration or that equalize municipal services.

One commenter took issue with the wording of this section which assumes that every public policy that has a negative effect on the cost of housing is bad and must be ameliorated. Many necessary policies needed to protect the public health and welfare, such as building codes and zoning ordinances, do generally increase the cost of housing. Yet, a plan to ameliorate the "negative effects" of these policies is absurd. The commenter asks that the regulation be rewritten to distinguish between "reasonable" policies from those which inordinately effect the cost of housing. The rule does not require a jurisdiction to have a plan to ameliorate negative effects of every public policy that has an impact on affordable housing. Of course, a jurisdiction will not develop a strategy to change policies that are required by Federal law or that are viewed as having effects that are beneficial to the public.

A second commenter concluded that this section would be much more useful if it called for an examination of the costs and benefits of the policies in question, addressing as well the issue of who pays and who benefits. The Department believes this type of requirement would exceed its authority under NAHA, but would welcome such discussions in CHAS submissions.

One commenter strongly recommended the inclusion of concrete examples of actions that localities and States should take to remove or ameliorate negative effects of public policies. Another commenter asked that this section require a description of the jurisdiction's provisions for the development of affordable housing in its zoning and building codes, suggesting that plans to eliminate "bad" code provisions be mentioned in this section of the CHAS. Certainly, zoning and building codes are prime examples of policies that should receive scrutiny under this section. Other public policies that might be considered are discussed in the July, 1991 report to the President by the Advisory Commission on Regulatory Barriers to Affordable Housing.

One advocacy agency commented that it preferred the earlier draft of the CHAS, which required jurisdictions to cite local barriers to affordable housing and explain why recommendations to eliminate those barriers were not

implemented. The statute does not permit the Department to require removal of barriers as a condition of CHAS approval. Therefore, the rules does not require an explanation of why actions have not been taken to remove them. However, if the CHAS does describe a plan to remove barriers, the performance report will be expected to describe the actions actually taken.

Although the rule text reflects the statutory language only, State and local jurisdictions are free to discuss policies that promote preservation, prevent displacement of low-income families, expand housing opportunities for minorities and equalize municipal services in this section.

L. Institutional Structure

Among the twenty-three comments addressing this section, fourteen recommended that the jurisdiction assess the existing and potential capacity of Community Housing Development Organization (CHDO) to productively use the funds being set aside for their use. They also recommended that the jurisdiction outline the steps that it is prepared to take in order to build capacity where it is lacking. Six commenters stressed the importance of disability organizations in the delivery system to ensure that the housing needs of the disabled are considered, while one commenter suggested that a voice for the homeless in this institutional structure would be encouraged by changing the term "housing strategy" where it appears in this section to "housing and homeless assistance strategy".

Assessment and involvement of CHDOs and disability organizations are both appropriate for discussion under this section. While the Department is not changing the term "housing strategy," both the rule and the accompanying instructions provide a strong emphasis on the nature and extent of homelessness and other persons with special needs requiring supportive housing and what facilities and services State and local jurisdictions have and are planning to provide.

In response to commenters concerned about intergovernmental cooperation in implementing a CHAS, a jurisdiction may describe under "Public Institutions," the section where a jurisdiction identifies the institutional structure through which it will carry out its affordable and supportive housing strategy, any intergovernmental cooperation and coordination taking place or contemplated among the State and any units of general local

governments in implementing the strategy.

M. Court Orders and Consent Decrees

Two commenters recommended that HUD issue specific instructions to jurisdictions under court orders or consent decrees with respect to assisted housing, to ensure that their housing strategies adequately address any obligations imposed by the judicial order. The rule requires State and local governments to specifically identify and explain any court orders (including a consent decree) or HUD-imposed sanctions that affect the provision of assisted housing or fair housing remedies. If none exist, that, too, should be stated.

Four commenters took issue with the language removing authority from the courts to enjoin activities which are being undertaken to implement an approved housing strategy during the pendency of an action challenging the adequacy of a strategy or the action of HUD in approving a strategy. The rule simply reflects the language of the statute on this issue.

N. Monitoring Procedures

Of the seven commenters responding on this topic, six suggested that the local governing body or the Chief Executive Officer should be required to approve a monitoring plan. One commenter contended that HUD should permit a jurisdiction to monitor under the same guidelines and reporting requirements already in place for the CDBG Program. One commenter requested that HUD provide guidance on developing local standards and procedures for monitoring. Other commenters suggested that HUD provide specific monitoring criteria, model procedures, and general reporting standards.

The CHAS, including the monitoring plan, is a document of the jurisdiction. Therefore, it must be signed by the Chief Executive Officer of the jurisdiction. Whether the CHAS is also approved by the local governing body is a matter for local determination.

The Department believes that the specific monitoring guidelines and reporting requirements of each program should be used. However, the Department will provide general monitoring guidelines.

O. Certifications

1. Fair Housing

Twenty commenters vehemently objected to the absence of strong provisions regarding fair housing and equal opportunity in the interim rule, fearing that this may give jurisdictions

the impression that HUD has lowered its fair housing standards. Eighteen of these commenters contended that, at minimum, the CHAS should include the CDBG program requirements (24 CFR 570.904), which require recipients to conduct a study of the impediments to fair housing choice and to analyze possible actions to remedy the discriminatory condition. Sixteen commenters recommended that the rule should contain provisions that would require each jurisdiction to analyze institutional, policy and procedural impediments to fair housing and develop programs to intervene in discriminatory practices and eliminate discriminatory institutional elements. One commenter believed that the requirement for a fair housing certification was inadequate to ensure compliance with fair housing laws and suggested that the CHAS rule specifically require that jurisdictions comply with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Civil Rights Act of 1866, the Community Reinvestment Act, the Home Mortgage Disclosure Act, and the Equal Credit Opportunity Act. Another commenter expressed concern about the absence of administrative or legal recourse for citizens who feel that a State or local CHAS does not adequately identify or provide remedies for barriers to fair housing.

The Department is developing a proposed rule that would define and provide guidelines on "affirmatively furthering fair housing." The Department believes that current administrative and legal procedures are generally adequate to address complaints with regard to fair housing until that rule is issued. However, this rule has been revised to specifically require that records be maintained pertaining to any steps taken to carry out the fair housing obligation, consonant with the statutory definition of "certification." (See §§ 91.21(c) and 91.46(c).)

That reference to records also has been amplified to indicate that the records may include the analysis of impediments to fair housing and the description of actions taken to overcome these impediments, as described in § 570.904(c). Such records would be satisfactory to support a certification that the jurisdiction is affirmatively furthering fair housing.

The question of whether a certification that a jurisdiction is affirmatively furthering fair housing could be challenged by HUD and be cause for disapproval of a CHAS submission is addressed in § 91.72 of this rule. If HUD determines that a certification is inaccurate, it has the

authority to reject the certification. Rejection of the certification would render the submission substantially incomplete and be cause for disapproval of the CHAS. HUD must provide the jurisdiction with notice and an opportunity to comment on its determination.

2. Replacement of Low-Income Housing and Relocation Assistance

All six commenters on this topic believed that the rule needed to be strengthened by specifically listing programs that are covered by residential antidisplacement and relocation assistance plans. The commenters went on to suggest that the CDBG antidisplacement plan should be appended to the CHAS so as to raise its visibility and to reinforce its role in the housing strategy. The Department believes a certification is sufficient for the housing strategy.

P. Citizen Participation

1. General

Twenty commenters responded to this topic. A large number of these commenters made suggestions to expand the citizen participation process to include specific groups in the process and to increase the level of citizen participation throughout all phases of CHAS development. Two commenters recommended that the CHAS document be required to be made available in accessible formats. Three commenters felt that copies of the CHAS document and any substantial amendments should be provided directly to disabled groups. Seven commenters contended that the citizen participation process should include outreach to homeless persons, persons with critical housing needs, low-income tenants who may be marginally housed, and people with special housing needs.

The Department has suggested in this final rule various means of outreach in order to engage more active participation from all groups which may have an interest.

Six commenters suggested that HUD prescribe a format for the CHAS forms and narrative that is understandable to citizens and is likely to enhance meaningful citizen participation. One commenter stated that HUD should include in the instructions, specific examples of ways that jurisdictions can facilitate input during the CHAS development process and that these should include broadly representative advisory task forces, surveys of and by community-based organizations, and neighborhood or regional public forums.

The Department believes that the standard outline for a housing strategy, a summary of the five-year plan, and simplification of the forms will go a long way in making the document more accessible and understandable to the public.

One commenters expressed concern regarding the lack of a process through which citizens can appeal to HUD if they disagree with specific CHAS documents. The commenter contended that such a mechanism would encourage jurisdictions to develop more thoughtful housing strategies. The statute does not authorize HUD to assure satisfaction of all citizens with a CHAS. However, HUD will be looking for compliance with citizen participation requirements when reviewing a submission for approval and may disapprove a CHAS as substantially incomplete if the jurisdiction has failed to follow these requirements.

2. Public Hearings

Twenty-one commenters responded to this section. Of these commenters, five objected to the lack of mandatory citizen participation during the initial development of the CHAS and recommended that the rule require jurisdictions to hold at least one additional hearing prior to or during the drafting of the CHAS. An additional six commenters felt that the rule should require one public hearing on the draft CHAS and another on the final CHAS document. Another commenter noted that the wording of the rule made it unclear whether the required hearing on "housing needs" and that on the "housing strategy" were one and the same. Another commenter felt that the public notice requirements should be extended to include public hearings for the issuance of the proposed CHAS, performance reports and substantial amendments.

The Department now requires that one or more public hearings on housing needs be conducted before the strategy is developed. The Department agrees with the commenters that one or more public hearings is appropriate on needs before the CHAS is developed. We believe that this placement of the hearing early in the CHAS development process more nearly reflects the statutory directive and will elicit more participation than a hearing after the document is prepared. If hearings are conducted at a later stage, they must provide a reasonable opportunity to review the draft CHAS.

Seven commenters contended that public hearings should be required for substantial amendments to the CHAS and for CHAS performance reports.

Although public notice of these actions must be given, there is no statutory requirement to require a hearing. Consequently, the rule requires none.

One commenter stated that public hearings should be required to be held in accessible sites. Eight commenters recommended that the rule require public hearing to be conducted in the evening, to maximize the opportunity for meaningful citizen participation. The final rule does require that public hearings be conducted at accessible locations and at convenient times.

One commenter stated that States should be required to conduct more than one public hearing. The rule does provide that States must conduct an appropriate number of hearings in various parts of the State to effectively solicit comments from the public.

One commenter disagreed with the provision concerning HOME consortia stating that a separate public hearing need not be held in each member jurisdiction. We have eliminated the language at issue.

Citizens of all the member jurisdictions will have an opportunity to comment on the CHAS submission. Member jurisdictions may wish to conduct separate public hearings on need. However, the citizen participation provisions of the rule only require that the jurisdiction submitting the CHAS (the HOME consortium) conduct the required public hearing.

3. Public Comment Period

Of the thirty-six commenters responding to this section, thirteen contended that the required sixty-day comment period was excessive. Of these thirteen, eleven suggested that a thirty-day comment period would be adequate and more appropriate. One commenter felt that the sixty-day comment period increased the likelihood that jurisdictions would have to do substantial amendments to their CHASs, since the CHAS would have to be prepared months before appropriation levels for Federal housing programs are known. The Department has reduced the minimum period to thirty days.

Seven commenters believed that the rule should require interpreters for non-English speaking residents at public hearings. Another commenter felt that jurisdictions should be required to schedule a reasonable number of geographically dispersed hearings. The Department is supportive of the idea of a jurisdiction providing for an interpreter, but is leaving such matters to local discretion. Similarly, the location of hearings is left to the jurisdiction's discretion.

4. Publicity

Fourteen commenters contended that the rule should explicitly identify types of publications other than newspapers of general circulation in which CHAS summaries should be published. Among the publications suggested were neighborhood newspapers, foreign language publications, housing advocacy and union publications, and publications likely to be read by low-income, elderly, disabled or homeless persons. One additional commenter requested guidance on what constituted an "appropriate" number of newspapers of general circulation and on the required content of a "summary" of the CHAS. Commenters also felt that notice of public hearing should be required to be printed in nonlegal portions of local newspapers and announced on local radio and television stations. Twelve commenters recommended that the rule require the CHAS to be made available at places where citizens most likely to benefit from assisted housing congregate. Five commenters believed that jurisdictions should be required to provide full copies of the CHAS to interested parties at no charge upon request.

Publication of summaries in appropriate newspapers or periodicals is a local determination, not one specified by regulation. The cost of providing free copies of the entire CHAS could be considerable. Therefore, HUD declines to require it.

5. Access to Records

The interim rule provided that before a jurisdiction could submit a housing strategy, it must provide citizens a reasonable length of time to review the proposed strategy and reasonable access to "records requiring any uses of assistance the jurisdiction may have received during the preceding five years." One commenter questioned whether the records referenced here apply only to programs funded through the Act, or other programs as well. This section (§ 91.60 of the final rule) applies to HUD funds and those used with HUD funds.

Six commenters felt that this section should be altered to have broader coverage. Access to proposed substantial amendments to the housing strategy and access to proposed performance reports is assured under the revised language of § 91.62. In addition, the final rule includes a new section on public access to documents (§ 91.68). It provides that citizens be afforded reasonable and timely access to the source of estimates of need used

in the development of the housing strategy and to the written comments received by the jurisdiction on the proposed strategy, amendments, or performance report.

Another commenter felt that jurisdictions should be required to directly provide copies of substantial amendments and performance reports to all interested parties. Whether (free) copies should be provided to all interested parties is a matter of local discretion.

6. Summary of Citizen Comments

Six commenters responded to this section by recommending that, in addition to a summary of citizen comments, the CHAS include a summary of citizen comments regarding needs and a summary of the comments received regarding the jurisdiction's performance during the previous year. Some commenters suggested that a written transcript of all citizen comments be made available for citizen review at a central location, while another suggested that HUD require jurisdictions to provide all citizen commenters with a summary of comments to ensure that all comments, whether favorable or unfavorable, are included.

Generally, public hearings on needs are governed by local law. Local law may require that a transcript be prepared, but HUD is not requiring one in this rule. The CHAS must contain a summary of citizen comments on the CHAS, and those comments may discuss needs. The annual performance report is also required to have a summary of citizen comments. A written transcript of verbatim comments is an expensive undertaking and not one that HUD is requiring, although many States and larger jurisdictions may voluntarily do this.

7. Resolution of Citizen Complaints

The ten commenters responding to the section on resolution of citizen complaints contended that the requirements should be more specific and stringent. The commenters recommended that HUD require that all written complaints be answered in writing. Eight of the commenters suggested that a 15-day deadline from date of receipt be imposed on responses to written requests, that all requests and responses be kept on file in a central location, and that HUD establish a procedure for resolving complaints not resolved at the jurisdictional level. One commenter recommended that HUD review all complaints and responses.

The Department believes that resolving disputes about how to meet

housing needs and how to establish priorities for assistance is best done at the jurisdictional level. While States and local governments must respond to citizen comments and complaints, reasonable time periods are best established without HUD-imposed timeframes. However, for CDBG entitlement grantees, existing regulations require that a response be provided within 15 working days, where practicable.

Q. CHAS Submission and Review

1. Submission of Housing Strategy

Two of the thirteen commenters responding to this section objected to the linkage of timely submission of a CHAS to "favorable allocation of Section 8 Program funding," since the Section 8 Program is not subject to CHAS requirements. Although Section 8 does not require a certification of consistency with a CHAS, NAHA provides that allocations for the Section 8 Certificate and Voucher Programs are to be made in a way that enables participating jurisdictions to carry out their strategies. However, this section has been revised to simply state the deadline and not elaborate on the impact of failure to satisfy it. The submission target date has been changed from October 31 in the interim rule to the period of October 1 to December 31 in the final rule, with December 31 being an actual deadline for submission. Since a certification of consistency with an approved CHAS is required for applicants for many HUD programs, jurisdictions are strongly encouraged to submit their housing strategy on October 1 to avoid the possibility that they or a non-profit operating in the jurisdiction would be unable to apply for assistance during the early part of a fiscal year.

One commenter contended that the requirement that a new five-year housing strategy be developed whenever new Census data becomes available is unnecessary. The commenter believed that needs so far outweigh available resources that only very substantial changes in data would justify preparation of a new CHAS. Another commenter suggested that the Department allow jurisdictions to amend the affected sections of the CHAS when new Census data becomes available, rather than requiring a new CHAS submission. One commenter asked for clarification on how often jurisdictions participating in the American Housing Survey and other special U.S. Census studies must submit a new CHAS.

The Department believes that the advent of a new decennial Census mandates a new complete submission after all data items are generally available. There are no special requirements imposed on those jurisdictions participating in the American Housing Survey or special U.S. Census studies.

Six commenters recommended that citizens be allowed to petition for a new housing strategy when a major change in the housing market or a natural disaster has occurred, if the jurisdiction does not voluntarily choose to do so. Citizens may communicate with their governments about the extent and content of the housing strategy at any point. The Department does not want to prescribe additional procedures about resolution of complaints.

2. Approval of Housing Strategy

Numerous commenters objected to the bases upon which a CHAS may be disapproved. Twenty-one commenters believed that the purposes of NAHA (section 103), standing alone, are neither broad enough nor specific enough to serve as a basis for a determination of inconsistency. They called for the seven objectives of National Housing Policy (section 102 of NAHA) to be combined with the five purposes (section 103 of NAHA) as bases for determining whether a CHAS is inconsistent with NAHA. The Department cannot expand upon the purposes of the act as a basis for disapproval, since the act specifically limits HUD's authority to disapprove to the "purposes of the act."

In the opinion of other commenters, the second criterion, that a CHAS submission is "not substantially complete", emphasizes the provision of data but does not ensure accuracy. These commenters suggested that a CHAS submission should be able to be disapproved on the basis of grossly erroneous needs and market data. If the jurisdiction uses Census data, HUD would not disapprove the CHAS on the basis of incomplete data. If the jurisdiction uses other data, the methodology for gathering the data must meet HUD standards in order to avoid rejection on the basis of incomplete data.

Other commenters maintained that the final rule should allow disapproval of a CHAS that fails to have a sufficiently specific strategy or whose priorities and programs do not address the most crucial housing needs identified. A strategy must meet the regulatory requirements, which do mandate a specific strategy. The adequacy of the strategy to meet the

needs identified is not within the scope of the incompleteness test. A statutory change would be needed to make such a change in the rule.

One commenter objected to the provision that prohibits HUD from disapproving a strategy based on the jurisdiction's adoption or continuation of a public policy identified as affecting the availability of affordable housing. The commenter contended that any public policy that results in a reduction of the amount of affordable housing should result in a disapproval. The statute directly prohibits the Department from disapproving a strategy based on a jurisdiction's adoption or continuation of a public policy which adversely affects the production of affordable housing.

3. Amendment and Resubmission of Housing Strategy

Three commenters expressed concern regarding the timeframe for resubmission of a CHAS that has been disapproved. The commenters felt that a resubmission due date 45 days from the date of first disapproval might prove inadequate in cases where major changes are needed. One commenter suggested that HUD allow a jurisdiction 60 days from the time that it receives the specific reasons for the disapproval to resubmit its CHAS. Another commenter suggested that the language of the rule be changed to allow "not less than 45 days" for resubmission. This is the statutory language. The Department believes that these timeframes are generally adequate. If a jurisdiction believes that it has good cause for submission or resubmission of a CHAS after the deadline, it may seek a waiver of the deadline from HUD.

Seven commenters suggested that, in the case of changes to or resubmission of a disapproved strategy, jurisdictions be required to notify the public and citizens be given the opportunity to comment. A change to, or resubmission of, a disapproved strategy does not require notification of, or comment by, the public. However, copies of the strategy eventually submitted by the jurisdiction must be made available to the public.

R. Performance Reports and Reviews

Of the eighteen commenters responding to these sections, six felt that the performance report should be provided in an easily understandable form for citizen review before submission to HUD. These commenters felt that the performance report should show how resources are spent by source, activity and location and that all government resources unexpended at

the end of the year should be documented. Another five commenters requested that the performance report contain information on the racial and ethnic status of persons assisted. Six commenters requested the inclusion of information on persons with disabilities.

The Department has developed a format for the annual performance report that parallels the contents of the one-year action plan. States and local governments are to discuss annual performance, including resources made available within the jurisdiction, how the available resources are utilized, and the households and persons assisted along with their racial and ethnic status. An assisted household or individual is one who has received benefit during the reporting period.

One commenter objected to HUD's intention to measure performance based on the number of families served, rather than how well a jurisdiction carried out its strategy. The statute requires statement of goals in terms of number of families served, and the Department feels a duty to evaluate its performance on that basis. Another commenter said that, as with reporting requirements in the Community Development Block Grant programs, there is a problem reporting on housing achievements for units that are vacant at the time of project commitment. Under the final rule, goals are not based on commitments but on the number of families that actually have received a benefit during the period. Therefore, a vacant unit cannot be reported as having accomplished a goal.

Six commenters suggested that HUD apply the same sanctions contained in § 91.75 of the interim rule regarding the failure to submit a performance report to jurisdictions that fail to perform. In § 91.82, the Department has maintained the sanctions regarding the failure to submit a satisfactory report. Failure to perform will be the subject of HUD comments in its report to the jurisdiction (and likely citizen comment, as well).

Four commenters noted that the October 31 due date for the performance report is unrealistic, given the time necessary to collect the information, analyze progress, prepare the report and comply with the citizen participation requirements. One commenter suggested that States be given at least 6 to 8 months after the end of the fiscal year to submit the performance report. Others recommended allowing at least 90 days after the end of the reporting year for submission.

The rule has been revised to allow additional time. Annual performance reports must be submitted no later than

December 31 for the prior Federal fiscal year.

S. Miscellaneous

1. Abbreviated Strategy

Four of the six commenters responding to this subject requested that the Department provide more detailed guidance on the applicability of and specific content requirements for abbreviated strategies. One of these commenters felt that only jurisdictions participating in the HOME Program should be required to do a full CHAS. Another commenter contended that the requirement to prepare a full CHAS constituted an undue burden on small CDBG entitlement communities. One commenter suggested language that would require that abbreviated strategies to include only those elements that directly relate to the program for which they are being submitted.

In § 91.25 of the final rule, the Department has detailed the contents of an abbreviated strategy and has streamlined the requirements (i.e., no data forms are required, discussion of only the elements directly related to the need identified and the program(s) being applied for). However, a full CHAS must be submitted by CDBG entitlement communities, insular areas, and HOME participating jurisdictions.

2. Special Cases

Two commenters requested clarification in the rule regarding the CHAS content requirements for HOME consortia and for CDBG entitlement communities participating in HOME consortia and urban county agreements. Section 91.23 of the rule addresses the requirements of a consortia submission. Each consortium is now required (instead of being permitted) to submit combined information for the Community Profile market condition and needs, as well as a combined Five-year Strategy. The Annual Plan must contain information for the entire consortium, as well as separate submissions for each CDBG entitlement community for investment plan and goals.

The interim rule was silent on this issue. The Department believes that it is necessary for each HOME consortium to have a consolidated CHAS. The jurisdiction is the consortium, and it must submit its CHAS and it must certify consistency with that document.

3. Waiver Authority

Seven commenters recommended that HUD require all jurisdictions requesting waivers under this section to provide citizens with notice and the opportunity to comment. Time constraints for

preparation and submission of a waiver request make this suggestion impracticable.

Another commenter suggested that the Department interpret "good cause" in connection with waiver request liberally and that the waiver authority be delegated to the Regional Office level. In accordance with the Department of HUD Reform Act of 1989 (Pub. L. 101-135, approved December 15, 1989), waivers can only be granted by a Departmental official of Assistant Secretary rank or higher. The provision of the interim rule requiring any waiver to be granted by the Secretary has been removed in this final rule, so that the authority may be delegated to the Assistant Secretary for Community Planning and Development.

V. Findings and Certifications

A. Environmental Review

A Finding of No Significant Impact with respect to the environment was made when the interim rule was issued, in accordance with HUD regulations at 24 CFR part 50 that implement section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332. The changes made in the interim rule and in this final rule do not change the program sufficiently to affect the validity of that Finding. The Finding of No Significant Impact is available for public inspection and copying during regular business hours in the Office of the Rules Docket Clerk, room 10276, 451 Seventh Street SW., Washington, DC 20410.

B. Impact on the Economy

This rule does not constitute a "major rule" as that term is defined in Section 1(b) of Executive Order 12291, Regulatory Planning Process. Analysis of the rule indicates that it does not: (1) Have an annual effect on the economy of \$100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

C. Federalism Impact

One commenter felt that the Department's finding of no substantial

impact on federalism is unwarranted given the interim rule's lack of clarity regarding the requirement for State and local coordination. The degree of State and local coordination is left to the determination of these governments in this final rule. This arrangement has the least intrusive effect on those governments, leaving the least federalism impact.

The same commenter supported the provision prohibiting the disapproval of a CHAS based on the adoption or continuation of a public policy by a jurisdiction that affects the availability of affordable housing, but expressed great concern about the proposal contained in the report of the Secretary's Commission on Barriers to Affordable Housing that would abrogate this principle. However, another commenter contended that the Department should drop this prohibition on disapproval to further encourage affordable housing. The final rule retains the provision prohibiting disapproval of a CHAS based on the adoption or continuation of a public policy affecting the availability of affordable housing, since the statute contains this limitation. The report of the Secretary's commission is the subject of legislative consideration, but no changes can be made in the rule without legislative action.

Another commenter objected to the absence of a federalism assessment in the interim rule. The federalism assessment is somewhat lengthy, and so it is prepared as a separate document for submission to the Office of Management and Budget. It is available for review by members of the public in the office of the Rules Docket Clerk, room 10276, Office of General Counsel, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410-0500 during the hours of 7:30 a.m. to 5:30 p.m. on regular business days.

In connection with the preparation of this final rule, the General Counsel, as the Designated Official under section 6(a) of Executive Order 12612, Federalism, has certified that the method of implementing the Comprehensive Housing Affordability Strategy requirements of the National Affordable Housing Act used in this final rule achieves the goals of the statute in a way that promotes the Federal objectives, while having the

least possible adverse effects on the operations and functions of the States and local governments.

D. Impact on the Family

The General Counsel, as the Designated Official under Executive Order 12806, The Family, has determined that this rule does not have potential significant impact on family formation, maintenance, and general well-being, and, thus, is not subject to review under the order. The rule governs the planning function of State and local governments in their efforts to provide affordable housing for families. Therefore, to some degree the rule has an indirect effect of promoting better living conditions for families. However, the changes in this rule from the interim rule are not likely to have any direct impact on families, as such.

E. Regulatory Agenda

This rule was listed as sequence number 1120 under the Office of the Secretary in the Department's Semiannual Regulatory Agenda published in April 27, 1992 (57 FR 16804, 16818), under Executive Order 12291 and the Regulatory Flexibility Act.

F. Impact on Small Entities

One commenter disagreed with the Department's finding that the Interim Rule had no significant economic impact on small entities. The commenter contended that the requirements exceed the minimum burden required by the Act in the way of a planning document. The Department has substantially modified and reduced the requirements associated with the preparation of a housing strategy and believes the burden is minimal in terms of a plan required by the statute. Furthermore, this final rule provides for abbreviated strategies, where appropriate, which will often be the case with small cities.

The Secretary, in accordance with the Regulatory Flexibility Act [5 U.S.C. 605(b)], has reviewed this final rule before publication and by approving it certifies that this rule will not have a significant impact on a substantial number of small entities.

G. Public Reporting Burden

The Department has determined that the following sections of the final rule contain information collection or recordkeeping requirements.

ANNUAL REPORTING BURDEN

FINAL RULE—COMPREHENSIVE HOUSING AFFORDABILITY STRATEGY

Rule provision	Number of respondents	Responses/ respondent	Hours per response	Burden hours
Five-year CHAS:				
Localities (91.15–23, 91.50–53)	800	1	391	312,800
States (91.40–48)	50	1	469	23,450
Annual Plan: ¹ (91.21, 46, 53)	850	1	158	134,300
Abbreviated strategy: ² (91.25)	100	1	100	10,000
Recordkeeping (included in above)	³ 850	1	12	(⁴)
	⁴ 100	1	4.5	(⁵)
Total burden				480,550

¹ Submitted in each of the four years following submission of the complete strategy.² Submitted by a jurisdiction instead of the complete CHAS.³ For complete CHAS.⁴ For abbreviated strategies.⁵ Included in above figures.

List of Subjects

24 CFR Part 91

Grant programs—Indians, Low and moderate income housing, Homeownership, Public housing.

24 CFR Part 570

Administrative practice and procedure, American Samoa, Community development block grants, Grant programs—housing and community development, Grant programs—education, Guam, Lead poisoning, Loan programs—housing and community development, Low and moderate income housing, Northern Mariana Islands, Pacific Islands Trust Territory, Puerto Rico, Reporting and recordkeeping requirements, Virgin Islands, Student aid.

Accordingly, parts 91 and 570 of title 24 of the Code of Federal Regulations are amended as follows:

PART 91—STATE AND LOCAL HOUSING AFFORDABILITY STRATEGIES

1. Part 91 is revised to read as follows:

Subpart A—General

Sec.

91.1 Purpose and applicability.

91.5 Definitions.

91.10 Review by courts.

Subpart B—Contents of Strategy: Local Governments

91.15 General.

91.17 Community profile.

91.19 Five-year strategy.

91.21 Annual plan.

91.23 Special case—Home consortia.

91.25 Special case—abbreviated strategy.

Subpart C—Contents of Strategy: States

91.40 General.

91.42 State profile.

91.44 Five-year strategy.

91.46 Annual plan.

91.48 Special case—District of Columbia.

Subpart D—Insular Areas

91.50 General.

91.51 Insular area profile.

91.52 Five-year strategy.

91.53 Annual plan.

Subpart E—Coordination and Consultation

91.55 Coordination of State and local housing strategies.

91.57 Consultation with social service agencies.

Subpart F—Citizen Participation

91.60 Preparation of housing strategy.

91.62 Substantial amendment to housing strategy or submission of performance report.

91.63 Minor amendment.

91.65 Resolution of citizen complaints.

91.68 Public access to documents.

Subpart G—HUD Review and Approval

91.70 Submission of housing strategy.

91.72 Approval of a strategy.

91.75 Actions in case of disapproval of a strategy.

91.78 Revision and resubmission of a housing strategy.

Subpart H—Use of Housing Strategy

91.80 Consistency certification.

91.82 Performance reports.

91.85 HUD performance reviews.

Subpart I—Miscellaneous

91.99 Waiver authority.

Authority: 42 U.S.C. 12701–12708; 42 U.S.C. 3535(d).

Subpart A—General

§ 91.1 Purpose and applicability.

(a) *Purpose.* The purpose of the State and local housing affordability strategy is to assure that jurisdictions receiving HUD assistance plan for the housing and related needs of very low-income, low-income, and moderate-income families in their jurisdictions in a way that improves the availability and affordability of decent, safe, and sanitary housing in a suitable living environment, including housing for

persons needing supportive services, using private resources as well as governmental ones, and including both homeownership and rental options.

(b) *Applicability.* In order to receive funding under certain HUD programs, a State or unit of general local government must have a Comprehensive Housing Affordability Strategy (CHAS or housing strategy) that has been approved by HUD.

(1) *Categories of program requirements.* In addition to the requirement to have a CHAS, each of the programs listed in paragraph (b)(2) of this section has specific certification requirements, which are set forth in the program regulations, guidelines, or notices of funding availability. They fall into the following categories:

(i) In certain HUD programs, a jurisdiction that is an applicant for funds must submit a certification that the proposed housing activities are consistent with the housing strategy of the jurisdiction.

(ii) In certain HUD programs, an applicant that is not a jurisdiction must obtain a certification by the public official responsible for submitting the housing strategy that the proposed housing activity is consistent with the approved housing strategy for the jurisdiction in which the proposed project will be located. The certification must be obtained from the lowest level of government that has an approved housing strategy.

(A) If the local government does not have an approved housing strategy, the applicant would have a few options. If the proposed project were consistent with the State CHAS, it could obtain a certification of consistency from the State. If the proposed project were not consistent with the State CHAS, it could ask the local government to prepare an abbreviated strategy (see § 91.25)

appropriate to the proposed project, or it could ask the State to amend its CHAS to make it consistent with the proposed project.

(B) If the local jurisdiction has an approved CHAS but the proposed project is not consistent with it, the applicant could ask the locality to amend its CHAS, to form the basis for a certification of consistency.

(iii) In certain HUD programs, an applicant that is a jurisdiction also must submit a certification that it is "following" an approved housing strategy.

(iv) In certain HUD programs, an applicant that is a jurisdiction must certify that the funds will be used pursuant to the jurisdiction's approved housing strategy.

(2) *Programs covered.* (i) The HOME Program (Title II of the Act; 24 CFR part 92);

(ii) The HOPE I (Public Housing Homeownership) Program (Secs. 411-419 of the Act, adding title III to the United States Housing Act of 1937);

(iii) The HOPE II Program (Homeownership of Multifamily Units) (Secs. 421-431 of the Act);

(iv) The HOPE III Program (Homeownership of Single Family Homes) (Secs. 441-448 of the Act);

(v) The Low-Income Housing Preservation Program (prepayment avoidance incentives, Secs. 601-613 of the Act, creating the Low-Income Preservation and Resident Homeownership Act of 1990), when administered by a State agency (see 24 CFR 248.177);

(vi) The Housing Opportunities Program for Persons with AIDS (Secs. 851-863 of the Act; 24 CFR part 574);

(vii) The Supportive Housing for the Elderly Program (Sec. 202 of the Housing Act of 1959, as amended by Sec. 801 of the Act; 24 CFR part 889);

(viii) The Supportive Housing for Persons with Disabilities Program (Sec. 811 of the Act, 24 CFR part 890);

(ix) The Homeless Housing Assistance Programs (Secs. 411-443 and 451-484 as amended by Sec. 837 of the Act) of the Stewart B. McKinney Homeless Assistance Act: Emergency Shelter Grants (24 CFR part 576); Transitional Housing (24 CFR part 577); Permanent Housing for Handicapped Homeless Persons (24 CFR part 578); Supplemental Assistance for Facilities to Assist the Homeless (24 CFR part 579); Single Room Occupancy Housing (24 CFR part 882, subpart H); and Shelter Plus Care (24 CFR Subtitle A, Appendix D); and

(x) The Community Development Block Grant Programs—Entitlement, Small Cities, States and Insular Areas (Secs. 106 and 107 of the Housing and

Community Development Act of 1974; see 24 CFR part 570).

(3) *Programs not covered.* Public Housing and Indian Housing funding (authorized under titles I and II of the United States Housing Act of 1937) is not dependent on the existence of, or a certification of consistency with, an approved housing strategy for the jurisdiction. Section 8 funding is not dependent on the existence of, or certification of consistency with, an approved housing strategy, except for the Section 8 Moderate Rehabilitation Single Room Occupancy Program (authorized under Section 441 of the McKinney Act). However, HUD funding allocations for the Section 8 Certificate and Voucher Programs are to be made in a way that enables participating jurisdictions to carry out their housing strategies (Sec. 556 of the Act). In addition, one basis for approval of rents for the Section 8 Programs that are higher than 110 percent of the fair market rents for the area based on special local conditions is a HUD determination that implementation of the approved housing strategy for the area requires the higher rents (Sec. 543(b) of the Act).

§ 91.5 Definitions.

Act. The Cranston-Gonzalez National Affordable Housing Act (Pub. L. 101-625, 104 Stat. 4079).

Annual plan. The component of the complete submission that specifies the jurisdiction's plan for the first Federal fiscal year covered by the submission, or the sole required submission in each of the four years after a complete submission was made. (See §§ 91.21 and 91.46.)

Assisted family. For purposes of identification of goals, in accordance with §§ 91.21(a)(1)(iv), 91.46(a)(1)(iv) and 91.52(a)(1)(iv), a family is assisted if, during the period covered by the annual plan, they will benefit through one or more programs included in the jurisdiction's investment plan. A renter is benefitted if the person takes occupancy of affordable housing that is newly acquired (standard housing), newly rehabilitated, or newly constructed, and/or receives rental assistance. An existing homeowner is benefitted during the year if the home's rehabilitation is completed. A first-time homebuyer is benefitted if a home is purchased during the year. A homeless person is benefitted during the year if the person becomes an occupant of transitional or permanent housing. A non-homeless person with special needs is considered as being benefitted, however, only if the provision of supportive services is linked to the

acquisition, rehabilitation, or new construction of a housing unit and/or the provision of rental assistance during the year. Families that will benefit from more than one program activity (e.g., a renter who receives rental assistance while occupying newly rehabilitated housing) must be counted only once. To be included in the goals, the family's housing unit must, at a minimum, satisfy the HUD Section 8 Housing Quality Standards (see, e.g., section 882.109).

Certification. A written assertion, based on supporting evidence which must be kept available for inspection by HUD, by the Inspector General of HUD, and by the public. The assertion shall be deemed to be accurate unless HUD determines otherwise, after inspecting the evidence and providing due notice and opportunity for comment.

Complete submission. A strategy prepared in accordance with subparts E and F that fulfills the requirements of subpart B, C, or D, as appropriate, with respect to the entire five-year period to follow.

Cost burden. The extent to which gross housing costs, including utility costs, exceed 30 percent of gross income, based on data available from the U.S. Census Bureau.

Disabled family. A family composed of one or more persons at least one of whom is an adult (a person of at least 18 years of age) who has a disability. A person shall be considered to have a disability if the person is determined to have a physical, mental or emotional impairment that:

(1) Is expected to be of long-continued and indefinite duration,

(2) substantially impedes his or her ability to live independently, and

(3) is of such a nature that the ability could be improved by more suitable housing conditions. A person shall also be considered to have a disability if he or she has a developmental disability as defined in section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001-6007). The term "disabled family" also includes the surviving member or members of any family described in the first sentence of this paragraph who were living in an assisted unit with the deceased member of the family at the time of his or her death.

Elderly family. For HUD rental programs, a family of no more than two persons in which the head of the household or spouse is at least 62 years of age.

Elderly person. A person who is at least 62 years of age.

Family. See definition in § 812.2, which differs from the Census definition.

Federal preference for admission. The preference given to otherwise eligible applicants under HUD's rental assistance programs who, at the time they seek housing assistance, are involuntarily displaced, living in substandard housing, or paying more than 50 percent of family income for rent. (See, for example, § 882.219.)

Homeless family. Family that includes at least one parent or guardian and one child under the age of 18, a homeless pregnant woman, or a homeless person in the process of securing legal custody of a person under the age of 18.

Homeless individual. An unaccompanied youth (17 years or younger) or an adult (18 years or older) without children.

Housing. Includes manufactured housing and manufactured housing lots.

Housing strategy (CHAS). A Comprehensive Housing Affordability Strategy prepared in accordance with this part, consisting of a complete submission, an annual plan, or an abbreviated strategy.

HUD. The United States Department of Housing and Urban Development.

Insular area. One of the following: the Northern Mariana Islands, the U.S. Virgin Islands, Guam, or American Samoa.

Jurisdiction. A State or unit of general local government.

Large families. Families of five or more persons.

Large family unit. A housing unit containing at least three bedrooms.

Low-income families. Families whose incomes do not exceed 80 percent of the median income for the area, as determined by HUD with adjustments for smaller and larger families, except that HUD may establish income ceilings higher or lower than 80 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or fair market rents, or unusually high or low family incomes. (This term corresponds to low and moderate-income households in the CDBG programs.)

Moderate-income families. Families whose incomes are between 80 percent and 95 percent of the median income for the area, as determined by HUD, with adjustments for smaller and larger families, except that HUD may establish income ceilings higher or lower than 95 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or fair market rents, or unusually high or low family incomes. (This definition differs from that for moderate-income households in the CDBG programs.)

Other low-income families. Families whose incomes qualify as "low-income" but not "very low-income", i.e., those whose incomes are between 50 percent and 80 percent of the median income for the area. (This term corresponds to moderate-income households in the CDBG programs.)

Overcrowding. A housing unit containing more than one person per room.

Participating jurisdiction. Any State or unit of general local government that has been so designated in accordance with the HOME Program (24 CFR part 92).

Primary housing activity. In the five-year strategy, a means of providing or producing affordable housing, such as rental assistance, production, rehabilitation, or acquisition, that will be allocated significant resources and/or will be pursued intensively for addressing a particular housing need.

Resubmission. A housing strategy that has been revised after being disapproved by HUD, which is then resubmitted to HUD.

Secondary housing activity. In the five-year strategy, a means of providing or producing affordable housing, such as rental assistance, production, rehabilitation, or acquisition, that will receive fewer resources and less emphasis than primary housing activities for addressing a particular housing need.

Severe cost burden. The extent to which gross housing costs, including utility costs, exceed 50 percent of gross income, based on data available from the U.S. Census Bureau.

State. Any State of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

Substantial amendment. A major change in an approved housing strategy. It involves a change to the five-year strategy, which may be occasioned by a decision to undertake activities or programs that are inconsistent with that strategy. A change to the annual plan that is consistent with the five-year strategy does not constitute a substantial amendment. (See § 91.63).

Unit of general local government. A city, town, township, county, parish, village, or other general purpose political subdivision of a State; an urban county; the insular areas, or a general purpose political subdivision thereof; a consortium of such political subdivisions recognized by HUD in accordance with the HOME Program (24 CFR part 92); and any agency or instrumentality thereof that is established pursuant to legislation and designated by the chief executive to act

on behalf of the jurisdiction with regard to HUD assistance.

Very low-income families. Low-income families whose incomes do not exceed 50 percent of the median family income for the area, as determined by HUD, with adjustments for smaller and larger families, except that HUD may establish income ceilings higher or lower than 50 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or fair market rents, or unusually high or low family incomes. (This term corresponds to low-income households in the CDBG programs.)

§ 91.10 Review by courts.

(a) The adequacy of information contained in a housing strategy about public policies affecting the affordability of housing shall not be reviewable by any Federal, State, or other court. Review of a housing strategy by any Federal, State, or other court shall be limited to determining whether the process of development and the content of the strategy are in substantial compliance with the requirements of the statute.

(b) During the pendency of any action challenging the adequacy of a housing strategy or the action of HUD in approving a strategy, the court shall not have the authority to enjoin activities taken by the jurisdiction to implement an approved housing strategy. Any housing assisted during the pendency of such action shall not be subject to any order of the court resulting from such action.

Subpart B—Contents of Strategy: Local Governments

§ 91.15 General.

(a) A complete housing strategy for a unit of general local government consists of the information required in §§ 91.15 through 91.21, submitted in accordance with the instructions prescribed by HUD. An abbreviated strategy consists of the information required in § 91.25.

(b) The jurisdiction shall describe the significant aspects of the process by which the housing strategy was developed, the identity of the agencies, groups, organizations, and others who participated in the process, and a description of the jurisdiction's consultations with social service agencies regarding the housing needs of children, elderly persons, persons with disabilities, homeless persons, and other persons served by such agencies. It shall also include a summary of the citizen

participation process, and a description of the efforts made to broaden public participation in the development of the CHAS. (See subparts E and F of this part.)

§ 91.17 Community profile.

(a) Market and inventory characteristics.

(1) Community description.—(i) Background and trends. In order to create a context for formulation of the CHAS, the jurisdiction shall describe the important historical, social, and economic factors and trends affecting housing affordability in the jurisdiction. It may also describe these factors and trends with respect to specific neighborhoods within the jurisdiction.

(ii) Demographics. The jurisdiction must present essential demographic data describing the general population (including trends in population), family, and racial and ethnic characteristics of the community. The jurisdiction must identify and describe any areas within the jurisdiction with concentrations of racial/ethnic minorities and/or low-income families, stating how it defines the terms "area of low-income concentration" and "area of racial/ethnic minority concentration" for this purpose. The locations and degree of these concentrations must be identified, either in a narrative or on one or more maps.

(2) Market and inventory conditions.—(i) General market and inventory. (A) Based on the data and information available, the jurisdiction must describe the significant general housing market and inventory conditions, including such aspects as supply, demand, condition, and cost of housing. Data on the housing inventory must include the ownership or rental status of units, whether they are occupied or vacant, their cost and size by number of bedrooms, and their structural condition, i.e., standard, substandard but suitable for rehabilitation, or substandard and not suitable for rehabilitation. (The jurisdiction must define in its CHAS the terms "standard condition" and "substandard condition but suitable for rehabilitation.") An assessment of the hazards of housing related environmental concerns, such as lead-based paint, should be included, to the extent information is available.

(B) The jurisdiction should indicate whether units are suitable for occupancy by elderly families, disabled families (including whether modifications are necessary to enable elderly and disabled people to remain in their homes), families with children, and any other category of need identified by the

jurisdiction. The impediments and opportunities created by these market conditions for providing affordable rental housing, promoting homeownership opportunities, alleviating overcrowding, and meeting the needs of underserved population groups, such as large families, should be highlighted.

(ii) Assisted housing inventory. This description shall include the total numbers of units assisted by a local, State or federally funded program, and an assessment of whether any such units are expected to be lost from the assisted housing inventory for any reason.

(A) The public housing inventory information shall include the total number of public housing units in the jurisdiction broken out by unit size, the number of vacant units, and a description of the condition and rehabilitation needs (including the need for modifying additional units to provide accessibility to persons with disabilities).

(B) Information about other assisted housing shall include, to the extent known, by unit size, the number of units assisted (including those occupied by tenants receiving tenant-based assistance), broken out by "elderly" or "family" type, under the Section 8 Housing Assistance Payments program; under the Section 202 program for the elderly; under the Section 811 program for persons with disabilities; under the Section 221(d)(3) and Section 236 interest reduction programs; and under the Farmers Home Administration Section 502 program. The number of these units that are vacant should be estimated.

(iii) Inventory of facilities and services for the homeless and persons threatened with homelessness. For homeless individuals or homeless families, the jurisdiction must estimate the number of emergency shelters, transitional housing for homeless persons, permanent housing for homeless persons with disabilities, and of the overnight sleeping capacity or number of housing units in each of these types of facilities. It also shall describe the availability of day shelters, soup kitchens and other facilities providing assistance on less than an overnight basis, and the nature and extent of the programs providing vouchers to assist homeless persons in obtaining shelter, meals, or services. It shall discuss the nature and extent of social service programs and describe the programs targeted to prevent low-income individuals and families with children from becoming homeless.

(iv) Inventory of supportive housing for non-homeless persons with special needs. The jurisdiction must describe the facilities and services that assist persons who are not homeless but who require supportive housing, such as the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addictions, persons diagnosed with AIDS and related diseases, and any other categories the jurisdiction specifies. This description must include estimates of the number and types of supportive housing, such as group homes, single-room occupancy (SRO), or other housing that includes a planned service component; efforts to coordinate service programs for addressing the needs of populations in supportive housing; and the nature and extent of programs for ensuring that persons returning to the community from mental and physical health institutions receive appropriate supportive housing.

(b) Needs assessment. Information included in this portion of the CHAS shall be based on data available from the U.S. Census, as updated by any properly conducted local study, or any other reliable source that the jurisdiction clearly identifies, and should reflect the consultation with social service agencies conducted in accordance with § 91.57 and the citizen participation process.

(1) Current estimates and five-year projections. The jurisdiction must discuss its estimate of the significant current needs for housing assistance separately for very low-income, other low-income, and moderate-income families by tenure type (renter/owner) and for different family categories (such as large families). To the extent that any racial or ethnic group has disproportionately greater need for any income category, family type, or tenure type, in comparison to the needs of that category as a whole, assessment of that specific need shall be included. The discussion shall include:

(i) Discussion of the cost burden and severe cost burden, overcrowding (especially for large families), and substandard housing conditions being experienced by very low-income, other low-income, and moderate-income renters and owners compared to the jurisdiction as a whole;

(ii) Examination and discussion of the local public housing agency's (PHA's) section 8, public housing (or combined) waiting list(s), including such aspects as the number of families on the list(s), when the list was last open and for how long, the percentage of those qualifying for a Federal preference for admission,

the PHA's system for applying the Federal preferences, its own local preferences, if any, and the factors influencing the composition of the waiting list;

(iii) The need for homeownership for first-time homebuyers;

(iv) To the extent data are available, as assessment of the housing needs of elderly persons and persons with disabilities who do not require supportive housing services; and

(v) Consideration of whether and how the jurisdiction's housing needs for current residents and those expected to reside in the area will change over the five-year period covered by the CHAS for each income group.

(2) *Nature and extent of homelessness.*—(i) *Needs of sheltered and unsheltered homeless.* The jurisdiction shall describe the nature and extent of homelessness within the jurisdiction, addressing separately the need for facilities and services for homeless individuals and homeless families, both sheltered and unsheltered, and, to the extent this information is available, by racial and ethnic group. Any numerical estimates must reflect methods for counting the homeless that eliminate or correct for duplicative reporting.

(ii) *Subpopulations.* To the extent the jurisdiction has data that were gathered using a methodology acceptable to HUD, it shall describe, within the sheltered and unsheltered categories, the need for facilities and services for homeless persons who are: severely mentally ill only, alcohol/other drug addicted only, severely mentally ill and alcohol/other drug addicted, fleeing domestic violence, homeless youth, diagnosed with AIDS and related diseases, and other categories that the jurisdiction identifies, and provide the percentages of these subgroups who are sheltered and unsheltered.

(iii) *Needs of persons threatened with homelessness.* The jurisdiction shall also describe the characteristics and needs of low-income individuals and families with children (especially those with incomes below 30 percent of area median income) who are currently housed but threatened with homelessness. A quantitative analysis is not required. If a jurisdiction provides estimates of the numbers of such individuals and families with children, it must include in the CHAS a definition of this population, and it must describe the method used to generate the estimate.

(3) *Populations with special needs—other than homeless.* The jurisdiction shall estimate, to the extent practicable, the number of persons who are not homeless but require supportive

housing, including the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addiction, persons diagnosed with AIDS and related diseases, and any other category the jurisdiction may specify, and describe their supportive housing needs. The jurisdiction also should assess the need of low-income families in public or assisted housing for a homeownership program, or an organized program to achieve economic independence and self-sufficiency identified in the public housing agency's Family Self-Sufficiency Program Plan, if any.

(c) *Available resources.* The jurisdiction shall list by activity type (e.g., acquisition, rehabilitation, new construction, homebuyer assistance, rental assistance, homeless assistance, homeless prevention), all resources and programs expected to be available to the jurisdiction from non-Federal public (i.e., State and local governments) and private sources for use in carrying out activities. The jurisdiction shall include among its resources, where the jurisdiction deems it appropriate, an identification of any publicly-owned land or property located in the jurisdiction that may be used to carry out the activities. A separate list shall describe Federal program resources, for which HUD will provide the information to be included. The jurisdiction should summarize its experience with these programs and evaluate their advantages and disadvantages in achieving affordable and supportive housing goals.

§ 91.19 Five-year strategy.

(a) *Summary of five-year strategy.* The jurisdiction is encouraged to provide a summary of the significant elements of its five-year plan for achieving its strategic purposes and objectives.

(b) *Priority analysis and strategy development.* The jurisdiction shall establish its general priorities for allocating Federal, State, and local governmental resources reasonably expected to be available, as well as any identified private resources over the next five-year period, geographically within the jurisdiction, among different activity types appropriate for meeting identified needs, and among different categories of low-income families with needs for housing and supportive housing assistance. This identification will include the type and size of family to be served and the types of activities to be undertaken, indicating a relative assignment for the importance of each priority from 1 (highest) to 3 (lowest), indicating "0" where the category is not

a priority at all. It must discuss the basis for assigning the relative priority given to a particular group's needs. When determining the relative priority, attention should be paid to the extent to which various categories of residents are already receiving housing assistance.

(1) *Analysis.* An analysis of each priority category of very low- and other low-income residents or activities shall consider how the size, distribution, condition, and cost of the jurisdiction's housing inventory matches the severity of needs and types of housing problems of each priority category of residents. (Family types may be grouped together for discussion where the analysis would apply to more than one of them.) The jurisdiction shall describe how this analysis provides the basis for establishing the category of residents or activity type as a priority. For very low-income renters, the analysis should discuss how the housing problems of households meeting Federal or local preferences for housing assistance were considered. The rationale for establishing the priorities and determining the relative numerical assignment of priorities should flow logically from the analysis.

(2) *Investment plan (activities and programs).* (i) For each category of residents assigned a priority, the jurisdiction shall describe the primary and secondary housing activities it plans to undertake and the programs and resources it plans to pursue over the coming five-year period to respond to the identified needs. Decisions about primary and secondary activities (as defined in § 91.5) and appropriate programs should be based upon their relative efficiency in addressing a particular housing need under the jurisdiction's current and anticipated housing market and inventory conditions, with primary activities being those judged most cost-effective and appropriate. The jurisdiction shall explain how these significant market characteristics influence its decisions about using funds and allocating investment among activities such as rental assistance, production of new units, rehabilitation of units (including modifications necessary to enable elderly and disabled people to remain in their homes), and acquisition of existing units.

(ii) The investment plan must include a description of the five-year strategy for addressing the emergency shelter and transitional housing needs of homeless individuals and families with children (including subpopulations), preventing low-income individuals and

families with children (especially those with incomes below 30 percent of median) from becoming homeless, and helping homeless individuals and homeless families make the transition to permanent housing and independent living.

(c) *Relevant public policies, court orders, and HUD sanctions.*—(1) *Public policies.* The jurisdiction shall describe all public policies, particularly those of the jurisdiction (including tax policies affecting land and other property, land use controls, zoning ordinances, building codes, fees and charges, growth limits, and policies that affect the return on residential investment), that affect the provision of affordable housing and assess the extent to which the costs or incentives to develop, maintain, or improve affordable housing are affected by each of these policies. For purposes of this paragraph, the term "public policies" includes policies embodied in the jurisdiction's statutes, ordinances, regulations, or administrative procedures and processes. The jurisdiction shall describe its strategy, including specific actions to be taken over the next five years, to remove or ameliorate any negative effects of the public policies.

(2) *Court orders and HUD sanctions.* The jurisdiction shall specifically identify and explain any court orders (including consent decrees) or HUD-imposed sanctions that affect the provision of assisted housing or fair housing remedies. It shall state how the court orders or sanctions affect resources and housing goals. If there are no court orders or sanctions, the jurisdiction must so state.

(d) *Institutional structure and intergovernmental cooperation.*—(1) *Description.* The jurisdiction must identify the institutional structure through which it will carry out its housing strategy. Each organization should be identified by type (public, private, profit or non-profit) and purpose (financial institution, planning agency, mental health agency, etc.). The relationships of the various organizations and the respective roles and responsibilities of each organization in carrying out the strategy must be described. With respect to public institutions, the jurisdiction must describe any intergovernmental cooperation and coordination taking place or contemplated.

(2) *Overcoming gaps.* (i) The jurisdiction shall assess the capacity of the institutional structure to carry out the housing strategy. It shall identify and discuss the existing strengths and gaps in the delivery of programs and services, including efforts to make use of

available housing, social service, and mental and other health care resources. The assessment also should discuss the gaps in program and service delivery that may result in persons becoming homeless.

(ii) The jurisdiction shall describe the actions to be taken over the next five years to eliminate identified gaps.

(e) *Public housing improvements.* The jurisdiction must describe the public housing agency's plan, including specific actions and steps to be taken over the next five years, to improve the management and operation of the public housing units located in the jurisdiction and to improve the living environment of public housing residents.

(f) *Public housing resident initiatives.* The jurisdiction must describe its activities to be undertaken over the next five years, in coordination with the local public housing agency, to encourage public housing residents to become more involved in the management of public housing and in acquiring ownership of their units.

(g) *Monitoring standards and procedures.* The jurisdiction shall describe its standards and procedures for monitoring activities undertaken with funds the jurisdiction receives from HUD. The standards and procedures described must provide for monitoring to be carried out on a regular basis to ensure that statutory and regulatory requirements are being met and that information submitted to HUD is correct and complete.

§ 91.21 Annual plan.

(a) *Strategy implementation.*—(1) *Investment plan.* For each priority category of residents or activities discussed in the five-year strategy that will receive attention during the coming Federal fiscal year, the jurisdiction shall identify the categories of residents to be assisted, housing activities to be undertaken, and all programs and resources in support of those activities for which it intends to apply to the Federal or State government, as well as its own funds that it will budget or that otherwise will be available for this purpose during the coming Federal fiscal year.

(i) Among the types of Federal resources to be identified are HUD programs, Farmers Home Administration programs, Department of Energy energy conservation programs, and the Low-Income Housing Tax Credit allocated to the jurisdiction. Among the types of non-Federal resources to be identified are the State and local governmental programs and any private resources that are available. In describing available resources, where

the jurisdiction deems it appropriate, it shall identify publicly-owned land or property located in the jurisdiction that could be used to carry out activities under the housing strategy.

(ii) The jurisdiction shall describe any matching requirement of the various funding sources to be used or for which it will apply, and how it anticipates meeting those requirements. It also shall specifically describe its plan for leveraging private and non-Federal funds by the use of Federal funds.

(iii) In addition to programs for which it plans to apply directly, the jurisdiction must identify programs for which it would be generally supportive of an application by another entity.

(iv) The jurisdiction must specify one-year goals for numbers of families to be assisted, by tenure type, under each activity specified with funds already on hand, including program income, and those funds to be available during the Federal fiscal year covered by the annual plan. (See definition of "assisted family" in § 91.5.)

(v) The jurisdiction must specify its actions during the next year to address emergency shelter and transitional housing needs of homeless individuals and homeless families, to prevent low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, and to help homeless persons make the transition to permanent housing and independent living.

(2) *Geographic distribution.* The jurisdiction shall specify the geographic areas in which it will direct assistance over the Federal fiscal year, giving its rationale for the selection and describing the nature of the impact the jurisdiction hopes to achieve in those areas through such investment. (The jurisdiction need only describe assistance that it will direct to one or more geographic areas within the jurisdiction; assistance not described by the jurisdiction will be presumed to be available anywhere within the jurisdiction.)

(3) *Service delivery and management.* The jurisdiction shall identify the governmental and other entities that will deliver and manage the specific housing assistance programs identified in the plan.

(b) *Other actions.* The jurisdiction shall describe the actions it plans to take in the Federal fiscal year to address relevant public policies, to develop institutional structure, to foster public housing improvements or resident initiatives. (See § 91.19(c)-(f).)

(c) *Certifications.* Each jurisdiction submitting a CHAS is required to submit a certification that it will affirmatively further fair housing and is required to maintain records pertaining to any steps taken to carry out the certification. These records may include the analysis of impediments to fair housing and the description of actions taken to overcome them described in 24 CFR 570.904(c). If a jurisdiction receives Community Development Block Grant funds, its CHAS also must include a certification that it is in compliance with a residential anti-displacement and relocation assistance plan under section 104(d) of the Housing and Community Development Act of 1974.

(d) *Summary of citizen comments and responses.* To demonstrate compliance with subpart F of this part, the jurisdiction must submit its summary of comments received from citizens concerning the housing strategy and its response.

§ 91.23 Special case—HOME Consortia.

(a) *General.* When two or more jurisdictions form a consortium for the purpose of receiving a formula allocation under the HOME program (24 CFR part 92), the consortium must submit a single, consolidated CHAS that covers the entire geographic area encompassed by the consortium as a condition funding. Where a consortium includes one or more Community Development Block Grant (CDBG) entitlement grantee (24 CFR part 570, subpart D), the entitlement community is not to submit a separate CHAS in addition to the consortium's CHAS.

(b) *Requirements for consolidated HOME consortium CHAS that covers an entitled community.* In addition to the information covering the entire consortium, the CHAS must contain an investment plan, covering the information required by § 91.21(a)(1)(i), (ii) and (iv), separately for each entitlement community.

§ 91.25 Special case—abbreviated strategy.

(a) *Who may submit an abbreviated strategy.* A jurisdiction that is not a CDBG entitlement community under 24 CFR part 570, subpart D, is not expected to be a participating jurisdiction (in the HOME program), and is not an insular area, may submit an abbreviated housing strategy that is appropriate to the types and amounts of assistance sought from HUD. (See §§ 91.50–91.52 for requirements applicable to insular areas.)

(b) *When is an abbreviated strategy necessary?*

(1) *Jurisdiction.* When a jurisdiction that is permitted to use an abbreviated strategy applies to HUD for funds under a program requiring an approved CHAS (see § 91.1(b)(2)), it must obtain approval of an abbreviated strategy, so that it can submit the required certification of consistency with a housing strategy.

(2) *Other applicants.* When an eligible applicant other than a jurisdiction (e.g., a PHA or nonprofit organization) seeks to apply for funding under a program requiring an approved CHAS (see § 91.1(b)(2)), the jurisdiction—if it is permitted to use an abbreviated strategy—may prepare an abbreviated strategy appropriate to the project. (See also § 91.1(b)(1)(ii)(A) and (B).)

(3) *Limitation.* There are limitations on submission of an abbreviated strategy for two of the programs for which an approved housing strategy is required (listed in § 91.1(b)(2)). For the HOME program, an abbreviated strategy is only permitted with respect to reallocations to other than participating jurisdictions (see part 92, subpart J). For the CDBG program, an abbreviated strategy may be submitted only for the Small Cities program.

(c) *Contents.* In an abbreviated strategy, a jurisdiction only must address the requirements described in this paragraph.

(1) *Market Characteristics.* Jurisdictions must provide information on market characteristics pertaining to the eligible population group(s) to be assisted by the program for which funds are being requested, or in the case of a request for HOPE funding, information pertaining to the homeownership market for the target population.

(2) *Needs data.* A jurisdiction must address its current needs for the population that is eligible to be assisted by the program for which funds are being requested (e.g., low-income and very low-income persons for the CDBG and HOME programs; homeless persons for the McKinney Act programs).

(3) *Homeless assistance strategy.* If McKinney Act funds are being applied for, the jurisdiction must include a description of its strategy for addressing the emergency shelter and transitional housing needs of homeless individuals and families with children, preventing low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, and helping homeless individuals and homeless families make the transition to permanent housing and independent living.

(4) *Investment plan.* A jurisdiction must indicate whether any additional

private or public resources will be used to address the identified needs. The strategy must clearly identify any Federal or State agencies that are providing or being requested to provide funds for the program(s) being applied for, and must identify any private or local resources drawn wholly or partially from other Federal funding sources.

(5) *Geographic distribution.* The geographic area (if other than the entire jurisdiction) that the strategy intends to serve for the target population(s) specified must be identified.

(6) *Fair housing.* A jurisdiction must provide a certification that it will affirmatively further fair housing and must maintain records pertaining to any steps taken to carry out the certification.

(7) *Replacement of low-income housing and relocation assistance.* A jurisdiction applying for assistance under the CDBG Small Cities program must provide a certification that it is in compliance with a residential anti-displacement and relocation assistance plan under section 104(d) of the Housing and Community Development Act of 1974.

(8) *Goals.* A jurisdiction must include a statement indicating the number of families or persons that will be assisted with the funds being requested under each program for which it is applying.

(d) *Procedure—(1) Citizen participation.* An abbreviated strategy and any amendment to it must be prepared in accordance with the citizen participation procedures of subpart F of this part.

(2) *Timing.* An abbreviated strategy must be submitted for HUD approval before or at the time of submission of the application for funding. A jurisdiction having an approved abbreviated strategy that decides at a later date to submit an application for assistance under one or more programs not consistent with the approved strategy, must submit an amended abbreviated strategy covering the new program(s) to HUD before or with the new application(s).

(e) *HUD review and approval.* An abbreviated strategy and any amended abbreviated strategy is subject to the review and approval requirements of subpart G of this part. An application for funds with respect to which HUD approval of a submitted abbreviated strategy is pending will either be put on hold until the strategy is approved or will be disapproved, dependent on the rules or time frames involved in the particular program(s) for which funds are being requested.

(f) *Performance reports.* The requirements of subpart G of this part apply to an abbreviated strategy. These annual reports must continue to be submitted by the jurisdiction in connection with an abbreviated strategy until completion of the project(s) or activities funded.

Subpart C—Contents of Strategy: States

§ 91.40 General.

(a) A complete housing strategy for a State consists of the information required in §§ 91.40 through 91.46, submitted in accordance with the instructions prescribed by HUD.

(b) The State has the discretion to structure, within the framework provided, its presentation of the required narratives, data, and tables for the entire State and for those sub-State areas and regions it considers to be significant and meaningful to the development of a housing strategy.

(c) The State is not required to present needs and market inventory data beyond that which is provided by HUD, except where data are being required "to the extent available".

(d) The State shall describe the significant aspects of the process by which the housing strategy was developed, the identity of the agencies, groups, organizations, and others who participated in the process, and a description of the State's consultations with social service agencies regarding the housing needs of children, elderly persons, persons with disabilities, homeless persons, and other persons served by such agencies. It shall also include a summary of the citizen participation process, and a description of the efforts made to broaden public participation in the development of the CHAS. (See subparts E and F of this part.)

§ 91.42 State profile.

(a) *Market and inventory characteristics—(1) Description of State—(i) Background and trends.* In order to create a context for formulation of the CHAS, the State shall describe the important historical, social, and economic factors and trends affecting the housing affordability in the State or in specific areas or communities within the State.

(ii) *Demographics.* The State must present essential demographic data describing the general population (including trends in population), family, and racial and ethnic characteristics of the State and describe any areas within the State with concentrations of racial/ethnic minorities and/or low-income

families, stating how it defines the terms "area of low-income concentration" and "area of racial/ethnic minority concentration" for this purpose. The locations and degree of these concentrations must be identified, either in a narrative or on one or more maps.

(2) *Market and inventory conditions.*

(i) *General market and inventory.* (A) Based on the data and information available to the State, it must describe the significant general housing market and inventory conditions Statewide, and for sub-State areas or regions considered appropriate, including such aspects as supply, demand, condition, and cost of housing. Data on the housing inventory must include the ownership or rental status of units, whether they are occupied or vacant, and their cost and size by number of bedrooms. An assessment of the hazards of housing related environmental concerns, such as lead-based paint, should be included, to the extent information is available. The discussion of the general market inventory shall also include an assessment of whether any rental housing is expected to be lost from the Federally assisted housing inventory administered by a State housing agency for any reason, including losses through demolition or conversion to homeownership, or through prepayment or voluntary termination of a Federally assisted mortgage. If no such losses are anticipated or there is no Federally assisted housing inventory being administered directly by a State housing agency, this must be clearly stated.

(B) To the extent available, the State may include information on the structural condition of the housing inventory, i.e., standard, substandard but suitable for rehabilitation, or substandard and not suitable for rehabilitation. (If the State does provide this description, the State must define in its CHAS the terms "substandard condition" and "substandard condition but suitable for rehabilitation", for the entire State or for sub-State areas.) The State may indicate whether units are suitable for occupancy by elderly families, disabled families (including whether modifications are necessary to enable elderly and disabled people to remain in their homes), families with children, and any other category of need identified by the State. The impediments and opportunities created by these market conditions for providing affordable rental housing, promoting homeownership opportunities, alleviating overcrowding, and meeting the needs of underserved population groups, such as large families, should be highlighted.

(ii) *Inventory of facilities and services for homeless persons and persons threatened with homelessness.* For homeless individuals and families with children, the State must provide a brief inventory of facilities and services that meet emergency shelter and transitional housing needs, such as estimates of the number of emergency shelters, transitional housing for homeless persons, permanent housing for homeless persons with disabilities, and of the overnight sleeping capacity or number of housing units of each of these types of facilities, the availability of day shelters, soup kitchens and other facilities providing assistance on less than an overnight basis and the nature and extent of the programs providing vouchers to assist homeless persons in obtaining shelter, meals, or services; discussion of the nature and extent of social service programs; and descriptions of the programs targeted to prevent low-income individuals and families with children from becoming homeless.

(iii) *Inventory of supportive housing for non-homeless persons with special needs.* The State must describe, to the extent information is available, the facilities and services that assist persons who are not homeless but who require supportive housing, including the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addictions, persons diagnosed with AIDS and related diseases, and any other categories the State specifies. This description must include estimates of the number and types of supportive housing such as group homes, single-room occupancy (SRO), or other housing that includes a planned service component; efforts to coordinate service programs for addressing the needs of populations in supportive housing; and the nature and extent of programs for ensuring that persons returning to the community from mental and physical health institutions receive appropriate supportive housing.

(b) *Needs assessment.* Information included in this portion of the CHAS shall be based on data available from the U.S. Census, as updated by any properly conducted study, or any other reliable source that the State clearly identifies, and should reflect the consultation with social service agencies conducted in accordance with § 91.57 and the citizen participation process.

(1) *Current estimates and five-year projections.* The State must discuss its estimate of significant current needs for housing assistance separately for very

low-income, other low-income, and moderate-income families by tenure type (renter/owner) and for different family categories (such as large families and single persons). To the extent that any racial or ethnic group has disproportionately greater need for any income category, family type, or tenure type, in comparison to the needs of that category as a whole, an assessment of that specific need shall be included. The discussion shall include:

(i) Discussion of the cost burden and severe cost burden, overcrowding (especially for large families), and substandard housing conditions being experienced by very low-income, other low-income, and moderate-income renters and owners;

(ii) For States administering Section 8 and public housing programs, examination and discussion of the State housing agency's waiting list(s) for assisted housing, including such aspects as the number of families or individuals on the list(s), when the list was last open and for how long, the percentage of those qualifying for Federal preferences for admission, the State housing agency's system for applying the Federal preferences, its own preferences, if any, and the factors influencing the composition of the waiting list;

(iii) The need for homeownership by first-time homebuyers;

(iv) To the extent data are available, an assessment of the housing needs of the elderly persons and persons with disabilities who do not require supportive housing services; and

(v) Consideration of whether and how the State's housing needs for current residents and those expected to reside in the State will change over the five-year period covered by the CHAS for each income group.

(2) *Nature and extent of homelessness*—(i) *Needs of sheltered and unsheltered homeless*. The State shall describe the nature and extent of homelessness within the State, addressing separately the need for facilities and services for homeless individuals and homeless families, both sheltered and unsheltered, and, to the extent this information is available, by racial and ethnic group. Any numerical estimates must reflect methods for counting the homeless that eliminate or correct for duplicative reporting.

(ii) *Subpopulations*. To the extent the State has data that were gathered using a methodology acceptable to HUD, it shall describe, within the sheltered and unsheltered categories, the need for facilities and services for homeless persons who are: severely mentally ill only, alcohol/other drug addicted only, severely mentally ill and alcohol/other

drug addicted, fleeing domestic violence, homeless youth, diagnosed with AIDS and related diseases, and other such categories as the State identifies, and provide the percentages of these subgroups who are sheltered and unsheltered.

(iii) *Needs of persons threatened with homelessness*. The State also shall describe the characteristics and needs of low-income individuals and families with children (especially those with incomes below 30 percent of area median income) who are currently housed but threatened with homelessness. A quantitative analysis is not required. If a State provides estimates of the numbers of such individuals and families with children, it must include in the CHAS a definition of this population and provide a description of the method used to generate the estimates.

(3) *Populations with special needs—other than homeless*. The State shall estimate, to the extent practicable, the number of persons who are not homeless but who require supportive housing, including the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addiction, persons diagnosed with AIDS and related diseases, and any other category the State may specify, and describe their supportive housing needs. The State should also assess the need of low-income families in public or assisted housing for a homeownership program or an organized program to achieve economic independence and self-sufficiency, as identified in the public housing agency's Family Self-Sufficiency Program Plan, if any.

(c) *Available resources*. The State shall list by activity type (e.g., acquisition, rehabilitation, new construction, homebuyer assistance, rental assistance, homeless assistance, homeless prevention), all resources and programs expected to be available to the State from non-Federal public and private sources for use in carrying out activities. The State shall include among its resources, where the State deems it appropriate, an identification of any publicly-owned land or property located in the State that may be used to carry out the activities. A separate list shall describe Federal program resources, for which HUD will provide the information to be included. The State should summarize its experience with these programs and evaluate their advantages and disadvantages in achieving affordable and supportive housing goals.

§ 91.44 Five-year strategy.

(a) *Summary of five-year strategy*. The State is encouraged to provide a summary of the significant elements of its five-year plan for achieving its strategic purposes and objectives.

(b) *Priority analysis and strategy development*. The State shall establish its general priorities for allocating Federal and State governmental resources reasonably expected to be available, as well as any identified private resources over the next five-year period, geographically within the State, among different activity types appropriate for meeting identified needs, and among different categories of very low- and other low-income families with needs for housing and supportive housing assistance. This identification will include the type and size of family to be served and the types of activities to be undertaken, indicating a relative assignment for the importance of each priority from 1 (highest) to 3 (lowest), indicating "0" where the category is not a priority at all. It must discuss the basis for assigning the relative priority given to a particular group's need. When determining relative priority, attention should be paid to the extent to which various categories of residents are already receiving housing assistance.

(1) *Analysis*. An analysis of each priority category of very low- and other low-income residents or activities shall consider how the size, distribution, condition, and cost of the jurisdiction's housing inventory matches the severity of needs and types of housing problems of each priority category of residents. (Family types may be grouped together for discussion where the analysis would apply to more than one of them.) The State shall describe how this analysis provides the basis for establishing the category of residents or activity type as a priority. For very low-income renters, the analysis should discuss how the housing problems of households meeting Federal or local preferences for housing assistance were considered. The rationale for establishing the priorities and determining the relative numerical assignment of priorities should flow logically from this analysis.

(2) *Investment Plan (activities and programs)*. (i) For each category of residents assigned a priority, the State shall describe the primary and secondary housing activities it plans to undertake and the programs and resources it plans to pursue over the coming five-year period to respond to the identified needs. Decisions about primary and secondary activities (as defined in § 91.5) and appropriate programs should be based on their

relative efficiency in addressing a particular housing need under the State's current and anticipated housing market and inventory conditions, with primary activities being those judged most cost-effective and appropriate. The State shall explain how these significant market characteristics influence its decisions about using funds and allocating investment among activities such as rental assistance, production of new units, rehabilitation of units (including modifications necessary to enable elderly and disabled people to remain in their homes), and acquisition of existing units.

(ii) The investment plan must include a description of the five-year strategy for addressing the emergency shelter and transitional housing needs of homeless individuals and families with children (including subpopulations), preventing low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, and helping homeless persons make the transition to permanent housing and independent living.

(b) *Relevant public policies, court orders, and HUD sanctions.*—(1) *Public policies.* The State shall describe all public policies, particularly those of the State (including tax policies affecting land and other property, land use controls, zoning ordinances, building codes, fees and charges, growth limits, and policies that affect the return on residential investment), that affect the provision of affordable housing and assess the extent to which the costs or incentives to develop, maintain, or improve affordable housing are affected by each of these policies. For purposes of this paragraph, the term "public policies" includes policies embodied in the State's statutes, regulations, or administrative procedures and processes. The discussion should also include an analysis of the extent to which State laws and policies permit local jurisdictions to develop or maintain excessive, exclusionary, discriminatory, or duplicative policies. The State shall describe its strategy, including specific actions to be taken over the next five years, to remove or ameliorate any negative effects of the public policies.

(2) *Court orders and HUD sanctions.* The State shall specifically identify and explain any court orders (including consent decrees) or HUD-imposed sanctions that affect the provision of assisted housing or fair housing remedies. It shall state how the court orders or sanctions affect resources and housing goals. If there are no court

orders or sanctions, the State must so indicate.

(c) *Institutional structure and intergovernmental cooperation.*—(1) *Description.* The State must identify the institutional structure through which it will carry out its housing strategy. Each organization should be identified by type (public, private, profit or non-profit) and purpose (financial institution, planning agency, mental health agency, etc.). The relationships of various organizations and the respective roles and responsibilities of each organization in carrying out the strategy must be described. With respect to public institutions, the State must describe any intergovernmental cooperation and coordination taking place or contemplated. The State shall specifically address the relationship between the State and local jurisdictions, their respective roles, and the extent to which the State plans to require local governments to assume responsibilities.

(2) *Overcoming gaps.* (i) The State shall assess the capacity of the institutional structure to carry out the housing strategy. It shall identify and discuss the existing strengths and gaps in the delivery of programs and services, including efforts to make use of available housing, social service, and mental and other health care resources. The assessment also should discuss the gaps in program and service delivery that may result in persons becoming homeless.

(ii) The State shall describe the actions to be taken over the next five years to eliminate identified gaps.

(d) *Low-income housing tax credits.* The State shall describe its strategy, including specific actions and steps to be taken over the five years, for coordinating the low-income housing tax credit with the development of housing for which rents are affordable to very low-income and other low-income families.

(e) *Public housing resident initiatives.* The State must describe its activities to be undertaken over the next five years to encourage residents of public housing operated by the State housing agency to become more involved in the management of public housing and in acquiring ownership of their units.

(f) *Monitoring standards and procedures.* The State shall describe its standards and procedures for monitoring activities undertaken with funds the State receives from HUD. The standards and procedures described must provide for monitoring to be carried out on a regular basis to ensure that statutory and regulatory

requirements are being met and that information submitted to HUD is correct and complete.

§ 91.46 Annual plan.

(a) *Strategy implementation.*—(1) *Investment plan.* For each priority category of residents or activities discussed in the five-year strategy that will receive attention during the coming Federal fiscal year, the State shall identify the categories of residents to be assisted, housing activities to be undertaken, and all programs and resources in support of those activities for which it intends to apply to the Federal government, as well as its own funds that it will budget or that otherwise will be available for this purpose during the coming Federal fiscal year.

(i) Among the types of Federal resources to be identified are HUD programs, Farmers Home Administration programs, Department of Energy energy conservation programs, and the Low Income Housing Tax Credit allocated to the State. Among the types of non-Federal resources to be identified are the State programs and any private resources that are available. In describing available resources, where the State deems it appropriate, it shall identify the publicly-owned land or property located in the State that could be used to carry out activities under the housing strategy.

(ii) The State shall describe any matching requirement of the various funding sources to be used and how it anticipates meeting those requirements. It also shall specifically describe its plan for leveraging private and non-Federal funds by the use of Federal funds.

(iii) In addition to programs for which it plans to apply directly, the State must identify programs for which it would be generally supportive of an application by another entity.

(iv) The State must specify one-year goals for numbers of families to be assisted, by tenure type, under each activity or program specified with funds already on hand, including program income, and those funds to be available during the Federal fiscal year covered by the annual plan. (See definition of "assisted family" in § 91.5.)

(v) The State must specify its actions during the next year to address emergency shelter and transitional housing needs of homeless individuals and homeless families, to prevent low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, and to help homeless persons make the transition to

permanent housing and independent living.

(2) *Geographic distribution.* The State shall specify the geographic areas in which it will direct assistance over the next Federal fiscal year, giving its rationale for the selection and describing the nature of the impact the State hopes to achieve in those areas through such investment. (The State need only describe assistance that it will direct to one or more geographic areas within the State; assistance not described by the State will be presumed to be available anywhere within the State.)

(3) *Service delivery and management.* The State shall identify the governmental and other entities that will deliver and manage the specific housing assistance programs identified in the plan.

(b) *Other actions.* The State shall describe the actions it plans to take during the Federal fiscal year to address relevant public policies, to develop institutional structure, to coordinate the Low-Income Housing Tax Credit, and to foster public housing resident initiatives. (See § 91.44(c)-(f).)

(c) *Certifications.* Each State submitting a CHAS is required to submit a certification that it will affirmatively further fair housing and is required to maintain records pertaining to any steps taken to carry out the certification. These records may include the analysis of impediments to fair housing and the description of actions taken to overcome them described in 24 CFR 570.904(c). If a State receives Community Development Block Grant funds, its CHAS also must include a certification that it is in compliance with a residential antidiscrimination and relocation assistance plan under section 104(d) of the Housing and Community Development Act of 1974.

(d) *Summary of citizen comments and responses.* To demonstrate compliance with subpart F of this part, the State must submit its summary of comments received from citizens concerning the housing strategy and its response.

§ 91.48 Special case—District of Columbia.

Although the District of Columbia is defined as a State for purposes of the Act, it must follow the strategy content requirements for a unit of local government with the addition of a description of its strategy to coordinate low-income housing tax credits.

Subpart D—Insular Areas

§ 91.50 General.

(a) A complete housing strategy for an insular area consists of the information required in §§ 91.50 through 91.53, submitted in accordance with the instructions and tables prescribed by HUD.

(b) The insular area shall describe the significant aspects of the process by which the housing strategy was developed, the identity of the agencies, groups, organizations, and others who participated in the process, and a description of the insular area's consultations with social service agencies regarding the housing needs of children, elderly persons, persons with disabilities, homeless persons, and other persons served by such agencies. It shall also include a summary of the citizen participation process, and a description of the efforts made to broaden public participation in the development of the CHAS. (See subparts E and F of this part.)

§ 91.51 Insular area profile.

(a) *Market and inventory characteristics—(1) Description of insular area.* (i) *Background and trends.* In order to create a context for formulation of the CHAS, the insular area shall describe the important historical, social, and economic factors and trends affecting housing affordability in the jurisdiction or in specific neighborhoods within the insular area.

(ii) *Demographics.* The insular area must present essential demographic data describing the general population (including trends in population), family, and racial and ethnic characteristics of the insular area.

(2) *Market and inventory conditions.* (i) *General market and inventory.* Based on the data and information available to the insular area, it must describe the significant general housing market and inventory in the insular area. This shall include a discussion of the entire insular area (and areas or communities within insular area that the insular area considers appropriate for discussion) general housing market in terms of supply, demand, condition, and cost of housing. To the extent information is available, the insular area must describe the ownership or rental status of units, whether they are occupied or vacant, and their cost and size by number of bedrooms, as well as information on the structural condition of the housing inventory, i.e., standard, substandard but suitable for rehabilitation, or substandard and not suitable for rehabilitation. (The insular area must

define in its CHAS the terms "substandard conditions" and "substandard condition but suitable for rehabilitation," for the entire insular area or for areas within the insular area.) The impediments and opportunities created by these market conditions on producing rental housing, promoting homeownership opportunities, alleviating overcrowding, and meeting the needs of underserved population groups, such as large families, should be highlighted. The discussion of the general market inventory shall also include an assessment of whether any rental housing is expected to be lost from the Federally assisted housing inventory administered by the insular area or public housing agency for any reason, including losses through demolition or conversion to homeownership, or through prepayment or voluntary termination of a Federally assisted mortgage. If no such losses are anticipated or there is no Federally assisted housing inventory being administered directly by the insular area or public housing agency, this must be clearly stated.

(ii) *Inventory of facilities and services for homeless persons and persons threatened with homelessness.* The insular area must estimate the number and give a brief description of emergency shelters, transitional housing for homeless persons, permanent housing for homeless persons with disabilities, and non-housing facilities (such as soup kitchens) providing assistance to homeless persons. The insular area shall also describe social service programs for homeless persons and programs to prevent low-income individuals and families with children from becoming homeless.

(iii) *Inventory of supportive housing for non-homeless persons with special needs.* To the extent information is available, the insular area must describe the facilities and services that assist persons who are not homeless but who require supportive housing, including the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addictions, persons diagnosed with AIDS and related diseases, and any other categories the insular area specifies. This description must include estimates of the number and types of supportive housing such as group homes, single-room occupancy (SRO), or other housing that includes a planned service component; efforts to coordinate service programs for addressing the needs of populations in supportive housing; and the nature and

extent of programs for ensuring that persons returning to the community from mental and physical health institutions receive appropriate supportive housing.

(b) *Needs assessment.* Information included in this portion of the CHAS shall be based on data available from the U.S. Census, as updated by any properly conducted local study, or any other reliable sources that the insular area clearly identifies, and should reflect the consultation with social service agencies conducted in accordance with § 91.57 and the citizen participation process.

(1) *Current estimates and five-year projections.* The insular area must discuss its estimate of the significant current needs for housing assistance for very low-income and other low-income families by tenure type (renter/owner) and for different size families. The insular area shall discuss whether and how the insular area's housing needs for current residents and those expected to reside in the insular area will change over the five-year period covered by the CHAS for each income group.

(2) *Nature and extent of homelessness.* The insular area shall describe the nature and extent of homelessness within the insular area.

(3) *Populations with special needs who are not homeless.* The insular area shall estimate, to the extent information is available, the number of persons who are not homeless but who require supportive housing.

(c) *Available resources.* The insular area shall list by activity type (e.g., acquisition, rehabilitation, new construction, homebuyer assistance, tenant assistance, homeless assistance, homeless prevention), all resources and programs expected to be available to the insular area from non-Federal public and private sources for use in carrying out activities. The insular area shall include among its resources, where the insular area deems it appropriate, an identification of any publicly-owned land or property located in the insular area that may be used to carry out the activities. The list will also include Federal program resources, for which HUD will provide the information to be included.

§ 91.52 Five-year strategy.

(a) *Priority analysis and strategy development.* The insular area shall establish its general priorities, to be pursued over the next five-year period, for allocating Federal, insular area, and any identified private resources reasonably expected to be available based upon analyses of the insular area's needs for housing assistance and its affordable and supportive housing

and services inventory. The strategy shall identify the categories (renter/owner and different family sizes) of very low- and other low-income families with housing needs that will be assisted, the different activity types the insular area determines to be appropriate for meeting the identified needs, and the geographic area within the insular area where activities will be undertaken. The insular area must also set forth its strategy for helping low-income families avoid becoming homeless; addressing the emergency shelter and transitional housing needs of homeless persons; and helping homeless persons make the transition to permanent housing and independent living.

(b) *Court orders and HUD sanctions.* The insular area shall identify and explain any court orders (including consent decrees) or HUD-imposed sanctions that affect the provision of assisted housing or fair housing remedies. It shall state how the court orders or sanctions affect resources and housing goals. If there are no court orders or sanctions, the insular area should so indicate.

(c) *Institutional structure and intergovernmental cooperation.*—(1) *Description.* The insular area must identify the institutional structure through which it will carry out its housing strategy. Each organization should be identified by type (public, private, profit or non-profit) and purpose (financial institution, planning agency, mental health agency, etc.). The relationships of the various organizations and their respective roles and responsibilities in carrying out the strategy must be described. With respect to public institutions, the insular area must describe any intergovernmental cooperation and coordination taking place or contemplated. The insular area shall specifically address the relationship between the insular area and local jurisdictions, their respective roles, and the extent to which the insular area plans to require local governments to assume responsibilities.

(2) *Overcoming gaps.* (i) The insular area shall assess the capacity of the institutional structure to carry out the housing strategy. It shall identify and discuss the existing strengths and gaps in the delivery of programs and services, including efforts to make use of available housing, social service, and mental and other health care resources. The assessment also should discuss the gaps in program and service delivery that may result in persons becoming homeless.

(ii) The insular area shall describe the actions to be taken over the next five years to eliminate identified gaps.

(d) *Public housing improvements.* If there is a public housing agency that manages and operates public housing in the insular area, the insular area must describe the strategy of the public housing agency, including specific actions and steps to be taken over the next five years, to improve the management and operation of the public housing units located in the insular area and to improve the living environment of public housing residents.

(e) *Public housing resident initiatives.* If there is public housing in the insular area, the insular area must describe its activities, to be taken over the next five years, in coordination with the public housing agency, to encourage public housing residents to become more involved in the management of public housing and in acquiring ownership of their units.

(f) *Monitoring standards and procedures.* The insular area shall describe its standards and procedures for monitoring activities undertaken with funds the insular area receives from HUD. The standards and procedures described must provide for monitoring to be carried out on a regular basis to ensure that statutory and regulatory requirements are being met and that information submitted to HUD is correct and complete.

§ 91.53 Annual plan.

(a) *Strategy implementation.*—(1) *Investment plan.* For each category of residents or activities discussed in the five-year strategy which will receive assistance during the coming Federal fiscal year, the insular area shall identify the categories of residents to be assisted, housing activities to be undertaken, and the programs and resources in support of those activities for which it intends to apply to the Federal government, as well as its own funds that it will budget or that otherwise will be available for this purpose during the coming Federal fiscal year.

(i) Among the types of Federal resources that should be identified are HUD programs, Farmers Home Administration programs, and Department of Energy energy conservation programs. Among the types of non-Federal resources to be identified are the insular area programs and any private resources that are available. In describing available resources, the insular area shall identify the publicly-owned land or property located in the insular area that it intends

to use over the coming year to carry out activities, if any.

(ii) The insular area shall describe any matching requirement of the various funding sources to be used and how it anticipated meeting those requirements. It also shall specifically describe its plan for leveraging private and non-Federal funds by the use of Federal funds.

(iii) In addition to programs for which it plans to apply directly, the insular area must identify programs for which it would be generally supportive of an application by another entity.

(iv) The insular area must specify one-year goals for numbers of families to be assisted, by tenure type, under each activity or program specified with funds already on hand, including program income, and funds to be available during the Federal fiscal year covered by the annual plan. (See definition of "assisted family" in § 91.5.)

(v) The insular area must specify its actions during the next year to address emergency shelter and transitional housing needs of homeless individuals and homeless families, to prevent low-income individuals and families with children (especially those with income below 30 percent of median) from becoming homeless, and to help homeless persons make the transition to permanent housing and independent living.

(2) *Geographic distribution.* The insular area shall specify the geographic areas in which it will direct assistance over the next Federal fiscal year, giving its rationale for the selection and describing the nature of the impact the insular area hopes to achieve in those areas through such investment.

(3) *Service delivery and management.* The insular area shall identify the governmental and other entities that will deliver and manage the specific housing assistance programs identified in the plan.

(b) *Other actions.* The insular area shall describe the actions it plans to take during the Federal fiscal year to develop institutional structure and to foster public housing resident initiatives.

(c) *Certifications.* The insular area must submit a certification that it will affirmatively further fair housing.

(d) *Summary of citizen comments and responses.* To demonstrate compliance with subpart F of this part, the insular area must submit its summary of comments received from citizens concerning the housing strategy and its response.

Subpart E—Coordination and Consultation

§ 91.55 Coordination of State and local housing strategies.

Methods of coordinating the development and implementation of housing strategies between and among a State and units of general local government that are participating jurisdictions within the State should be established. States are encouraged to take a leadership role in convening meetings to coordinate efforts to increase the availability of affordable housing. A unit of general local government need not seek approval of any elements of its housing strategy by the State government, nor may the State require such approval for purposes of this part. In addition to State/local government coordination, local governments in close proximity to one another should coordinate their housing strategies.

§ 91.57 Consultation with social service agencies.

In the preparation of its housing strategy, a jurisdiction must make reasonable efforts to confer with social service agencies (both public and private) regarding the housing needs of children, elderly persons, persons with disabilities, homeless persons, and other persons served by the agencies.

Subpart F—Citizen Participation

§ 91.60 Preparation of housing strategy.

Before submitting a housing strategy under this part, a jurisdiction must complete the following actions:

(a) *Public hearings.* (1) The jurisdiction must hold one or more public hearings to obtain the views of citizens, public agencies, and other interested parties on the housing needs of the jurisdiction during the CHAS development period and, for Fiscal Year 1994 and thereafter, it must be conducted before the 30-day period for public comment on the proposed CHAS. The hearings held on housing needs must be held in accessible meeting places and locations and at convenient times, giving reasonable notice to the public and making reasonable efforts to inform interested groups (e.g., public housing resident, homeless advocacy, and housing-related nonprofit organizations). The hearings on housing needs for housing strategy development may be combined with other public hearings required in the CDBG program, provided that the requirements of the two programs are treated separately. In the case of a State, there must be an appropriate number of hearings held in various parts of the State to effectively

solicit comments from the public affected by the housing strategy.

(2) Any hearings held during the comment period should be scheduled so that the public has had a reasonable opportunity to review the draft CHAS and has sufficient time to comment prior to its submission to HUD.

(b) *Publication of strategy.* The jurisdiction must make available to the public for comment the proposed housing strategy for the jurisdiction, which is based on the determination of housing needs made after public hearing(s), by publishing a summary of the proposed strategy in one or more newspapers of general circulation, and by making copies of the housing strategy available at libraries, government offices and other public places.

(1) The summary must describe the content (priorities for assisting categories of residents and types and locations of activities to be undertaken) and the purpose of the strategy. It must include a list of the locations where copies of the entire strategy may be examined.

(2) The CHAS package released for public examination and comment must include all required tables, narratives, and attachments to be submitted to HUD. For a proposed annual plan, the jurisdiction must also make available to the public the five-year strategy, to-date annual plans, and any amendments.

(3) The jurisdiction also may publicize the availability of the proposed strategy by press releases, contacts with radio and television stations as well as with the print media, contacts with neighborhood organizations, and organizations that serve particular groups that might be affected by the strategy.

(c) *Public comment period.* The jurisdiction must give affected citizens, public agencies, and other interested parties a reasonable length of time (at least 30 days) to examine the proposed housing strategy and to submit comments.

(d) *Access to records.* The jurisdiction must provide citizens, public agencies, and other interested parties with reasonable access to records regarding uses of assistance the jurisdiction received during the preceding five years, consistent with any State and local laws regarding privacy and obligations of confidentiality.

(e) *Consideration of comments.* The jurisdiction must consider any comments or views of citizens. The jurisdiction must prepare a summary of the comments received from citizens and provide an explanation of why specific recommendations received were

not accepted, if any. This summary is to be submitted to HUD as part of the housing strategy. The complete package submitted to HUD and the subsequently approved strategy must be made available to the public.

§ 91.62 Substantial amendment to housing strategy or submission of performance report.

Before submitting any performance report or substantial amendment to a housing strategy, a participating jurisdiction must provide citizens with reasonable notice of (at least 30 days), access to, and opportunity to comment on, the performance report or substantial amendment, and it must consider any comments or views of citizens. When a substantial amendment to a housing strategy, or a performance report is submitted, it must include a summary of citizen views received. The amendment or report must be made available to the public.

§ 91.63 Minor amendment.

The citizen participation requirement for a housing strategy amendment that does not rise to the level of a substantial amendment, as defined in § 91.5, is to inform the public of the change by publication of the description of the change concurrently with its submission to HUD. The jurisdiction is not required to solicit comment on the change.

§ 91.65 Resolution of citizen complaints.

A jurisdiction must establish appropriate and practicable procedures to handle complaints from citizens related to the housing strategy or performance reports. At a minimum, the jurisdiction must provide a timely, substantive response to every written citizen complaint, either orally or in writing, within an established period of time (within 15 working days, where practicable, if the jurisdiction is a CDBG grantee).

§ 91.68 Public access to documents.

The source of estimates of need used in the development of the housing strategy must be made available to all interested persons upon request. Copies of written comments received by the jurisdiction on the proposed housing strategy or amendments must be made available to the public.

Subpart G—HUD Review and Approval

§ 91.70 Submission of housing strategy.

(a) *General.* Except as provided in §§ 91.25(d)(1) and 570.306(c), a housing strategy with an annual plan covering the Federal fiscal year (October 1 of that year through September 30 of the following year) must be submitted

annually between October 1 and December 31, with December 31 being the deadline for submission.

(b) *Type of submission.* The first time a housing strategy is submitted, it must be a complete submission (as defined in § 91.5), or an abbreviated strategy, if appropriate. Thereafter, the annual submission will be an annual plan, as defined in § 91.5, until five years after the previous complete submission. However, when major new census data become available, a complete housing strategy must be submitted. Whenever a complete submission is made, the five-year cycle starts over again.

§ 91.72 Approval of a strategy.

(a) HUD will review the housing strategy upon receipt. Any housing strategy will be deemed to have been approved, unless HUD determines, within 60 days after receipt of the strategy, one of the following:

(1) The strategy is inconsistent with the purposes of the Act. The purposes of the Act are the following:

(i) To help families not owning a home to save for a down payment for the purchase of a home;

(ii) To retain, wherever feasible, as housing affordable to low-income families, those dwelling units produced for such purpose with Federal assistance;

(iii) To extend and strengthen partnerships among all levels of government and the private sector, including for-profit and nonprofit organizations, in the production and operation of housing affordable to low-income and moderate-income families;

(iv) To expand and improve Federal rental assistance for very low-income families; and

(v) To increase the supply of supportive housing, which combines structural features and services needed to enable persons with special needs to live with dignity and independence.

(2) The CHAS submission is not substantially complete under the following circumstances:

(i) Information submitted to satisfy the requirements of subparts B through F is not substantially complete;

(ii) A certification is rejected because HUD has determined it to be inaccurate, after opportunity for comment by the jurisdiction;

(iii) The jurisdiction failed to follow the citizen participation requirements of subpart F; or

(iv) The jurisdiction failed to follow the requirements of subpart E for consultation with social service agencies.

(b) HUD may not disapprove a housing strategy based on the

jurisdiction's adoption or continuation of a public policy affecting the availability of affordable housing.

§ 91.75 Actions in case of disapproval of a strategy.

(a) If HUD disapproves a housing strategy, it will immediately notify the jurisdiction of the disapproval. Not later than 15 days after HUD's communication of the disapproval, the Department must inform the jurisdiction in writing of the following:

(1) The reasons for the disapproval;

(2) The actions that the jurisdiction could take to meet the criteria for approval; and

(3) The time within which amendments to, or the resubmission of, a strategy will be permitted under § 91.78.

(b) If HUD fails to inform the jurisdiction of the reasons for disapproval within the 15-day period, the housing strategy will be deemed to have been approved.

§ 91.78 Revision and resubmission of a housing strategy.

HUD will permit revisions to, or resubmission of, any housing strategy that is disapproved, for a period of 45 days following the date of the written disapproval. HUD will approve or disapprove a housing strategy within 30 days after receiving the revisions or resubmission.

Subpart H—Use of Housing Strategy

§ 91.80 Consistency certification.

(a) A jurisdiction's certification that an application is consistent with its housing strategy means that the jurisdiction's annual plan indicates the jurisdiction planned to apply for the program or was willing to support an application by another entity for the program; the location of the activities is consistent with the geographic areas specified in the annual plan; and the activities benefit a category of residents for which the jurisdiction's five-year strategy shows a priority.

(b) The certification of consistency shall be made with respect to the jurisdiction's CHAS that contains an annual plan for the Federal fiscal year that covers the application submission deadline; *except that* where a competitive funding application submission deadline falls between October 1 and December 31, the certification of consistency may be made with respect to the jurisdiction's CHAS (including annual plan) for the prior fiscal year if the jurisdiction has not yet submitted its CHAS (including annual plan) for the current fiscal year,

unless the notice of funding availability provides otherwise.

§ 91.82 Performance reports.

(a) *General.* Each jurisdiction that has an approved housing strategy shall annually review and report, in a form prescribed by HUD, on the progress it has made in carrying out its housing strategy. The report must provide information on the funding made available, the types of activities undertaken, and other actions indicated in the five-year strategy and annual plan. In addition, information must be provided concerning the number and types of families assisted, including the number of very low-income and other low-income persons assisted and the racial and ethnic status of persons assisted.

(b) *Submission.* Reports must be submitted to the HUD Field Office no later than December 31 of each year covering performance for the period of October 1 through September 30 of the Federal fiscal year just ended.

(c) *Failure to report.* If a jurisdiction fails to submit a report satisfactory to HUD in a timely manner, HUD may take one of the following actions with respect to assistance to the jurisdiction under the HOPE Program, the Community Development Block Grant Programs, or the Homeless Housing Assistance Programs:

(1) Suspend assistance until a satisfactory report is submitted to HUD; or

(2) Withdraw and reallocate the assistance if HUD finds, after notice and opportunity for a hearing, that the jurisdiction will not submit a satisfactory report. Hearings will be governed by the procedures set forth at 24 CFR part 92, subpart L, or 24 CFR part 570, as appropriate.

(d) *Documentation of assistance provided.* Documentation of assistance provided to each family must be maintained by the jurisdiction or other

entity providing the assistance, or, in the case of Federal funds received by the State but distributed to a unit of general local government, by the unit of general local government receiving the Federal funds through the State. However, for each program, the jurisdiction (including a State) must keep a summary record of each family assisted and must make this summary available for inspection by the public during the performance report public comment period and by HUD.

§ 91.85 HUD performance reviews.

(a) *General.* HUD must review the activities of each jurisdiction that has an approved housing strategy at least annually. The review must include, insofar as practicable, on-site visits by HUD and must include an assessment of the jurisdiction's—

(1) Management of funds made available under programs administered by HUD;

(2) Compliance with its housing strategy;

(3) Accuracy in the preparation of performance reports under § 91.80; and

(4) Efforts to ensure that housing assisted under programs administered by HUD are in compliance with contractual agreements and the requirements of law.

(b) *Report by HUD.* HUD must report to the jurisdiction on its performance review in writing and give the jurisdiction not less than 30 days to review and comment on the report. After taking into consideration the comments of the jurisdiction, HUD may revise the report and must make the jurisdiction's comments and the report, with any revisions, readily available to the public within 30 days after receipt of the jurisdiction's comments.

Subpart I—Miscellaneous

§ 91.99 Waiver authority.

Upon determination of good cause, HUD may, subject to statutory

limitations, waive any provision of this part. Each such waiver must be in writing and must be supported by documentation of the pertinent facts and grounds.

PART 570—COMMUNITY DEVELOPMENT BLOCK GRANTS

3. The authority citation for part 570 is revised to read as follows:

Authority: 42 U.S.C. 5301-5320; 42 U.S.C. 3535(d).

4. In § 570.306, paragraphs (b) and (c) are revised, to read as follows:

§ 570.306 Comprehensive housing affordability strategy.

(b) *Recipient's responsibilities.* Each recipient is responsible for following a current HUD-approved CHAS. Each CDBG housing or housing-related activity must be consistent with the CHAS, as defined in part 91.

(c) *Newly entitled communities.* Any newly entitled community that is not a member of a consortium under the HOME program (24 CFR part 92) and that was not notified by HUD of its CDBG entitlement status for a fiscal year by April 1 before the fiscal year starts, shall be considered unable to prepare a CHAS early enough to meet the CHAS submission deadline. As a result, it will be permitted, for that year only, to submit its CHAS as soon as possible, and in any event soon enough to permit it to make the submission required under § 570.302 before the grant is awarded.

Dated: August 7, 1992.

Jack Kemp,

Secretary.

[FR Doc. 92-20941 Filed 8-31-92; 8:45 am]

BILLING CODE 4210-32-M

Tuesday
September 1, 1992

Part VII

**Office of Personnel
Management**

5 CFR Part 550

Pay Administration (General); Payments
During an Evacuation Caused by Natural
Disasters, Interim Rule

**OFFICE OF PERSONNEL
MANAGEMENT**

5 CFR Part 550

**Pay Administration (General);
Payments During an Evacuation**

AGENCY: Office of Personnel
Management.

ACTION: Interim rule with request for
comments.

SUMMARY: The Office of Personnel
Management is removing a restriction in
the regulations on payments during an
evacuation to permit Federal agencies to
make such payments when the
evacuation is occasioned by natural
disasters.

DATES: Interim regulations effective on
September 1, 1992. Comments must be
received on or before October 1, 1992.

ADDRESSES: Comments may be sent or
delivered to Barbara L. Fiss, Assistant
Director for Pay and Performance,
Personnel Systems and Oversight
Group, U.S. Office of Personnel
Management, room 7H28, 1900 E Street
NW., Washington, DC 20415.

FOR FURTHER INFORMATION CONTACT:
Jane R. Kuhl, (202) 606-2858.

SUPPLEMENTARY INFORMATION: Sections
5522 and 5523 of title 5, United States

Code, respectively, authorize agency
heads to—(1) Make advance
payments of up to 30 days pay,
allowances, and differentials, and (2)
continue payment of pay, allowances,
and differentials for certain periods
when employees are prevented from
performing their duties by an evacuation
that has been officially approved or
ordered. Section 550.405 of title 5, Code
of Federal Regulations, prevents agency
heads from making payments under
sections 5522 and 5523 when the
evacuation has been occasioned by a
natural disaster within the 48 contiguous
States or the District of Columbia. The
devastation caused by Hurricane
Andrew has caused OPM to reassess
the appropriateness of this restriction.
OPM believes that this regulation no
longer serves a useful purpose. In order
to facilitate immediate and effective
response to this unprecedented disaster,
OPM is removing this restriction.

Waiver of Delay in Effective Date

Pursuant to 5 U.S.C. 553(d)(3), I find
that good cause exists for making this
rule effective in less than 30 days. The
regulation is being made effective
immediately in order to make this
benefit available to employees on the
earliest practicable date.

E.O. 12991, Federal Regulation

I have determined that this is not a
major rule as defined under section 1(b)
of E.O. 12991, Federal Regulation.

Regulatory Flexibility Act

I certify that this regulation will not
have a significant economic impact on a
substantial number of small entities,
since it applies only to Federal agencies
and Federal employees.

List of Subjects in 5 CFR Part 550

Administrative practice and
procedure, Claims, Government
employees, Wages.

U.S. Office of Personnel Management.

Douglas A. Brook,
Acting Director.

Accordingly, OPM is amending part
550 of title 5 of the Code of Federal
Regulations as follows:

**PART 550—PAY ADMINISTRATION
(GENERAL)**

1. The Authority citation for subpart D
of part 550 continues to read as follows:

Authority: 5 U.S.C. 5527, E.O. 10982, 3 CFR
1959-1963 Comp., p. 502.

§ 550.405 [Removed]

2. § 550.405 is removed and reserved.

[FR Doc. 92-21210 Filed 8-31-92; 9:56 am]

BILLING CODE 6325-01-M

Reader Aids

Federal Register

Vol. 57, No. 170

Tuesday, September 1, 1992

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CFR PARTS AFFECTED DURING SEPTEMBER

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

LIST OF PUBLIC LAWS

Note: No public bills which have become law were received by the Office of the Federal Register for inclusion in today's List of Public Laws.

Last List August 31, 1992

FEDERAL REGISTER PAGES AND DATES, SEPTEMBER

39597-40070.....1

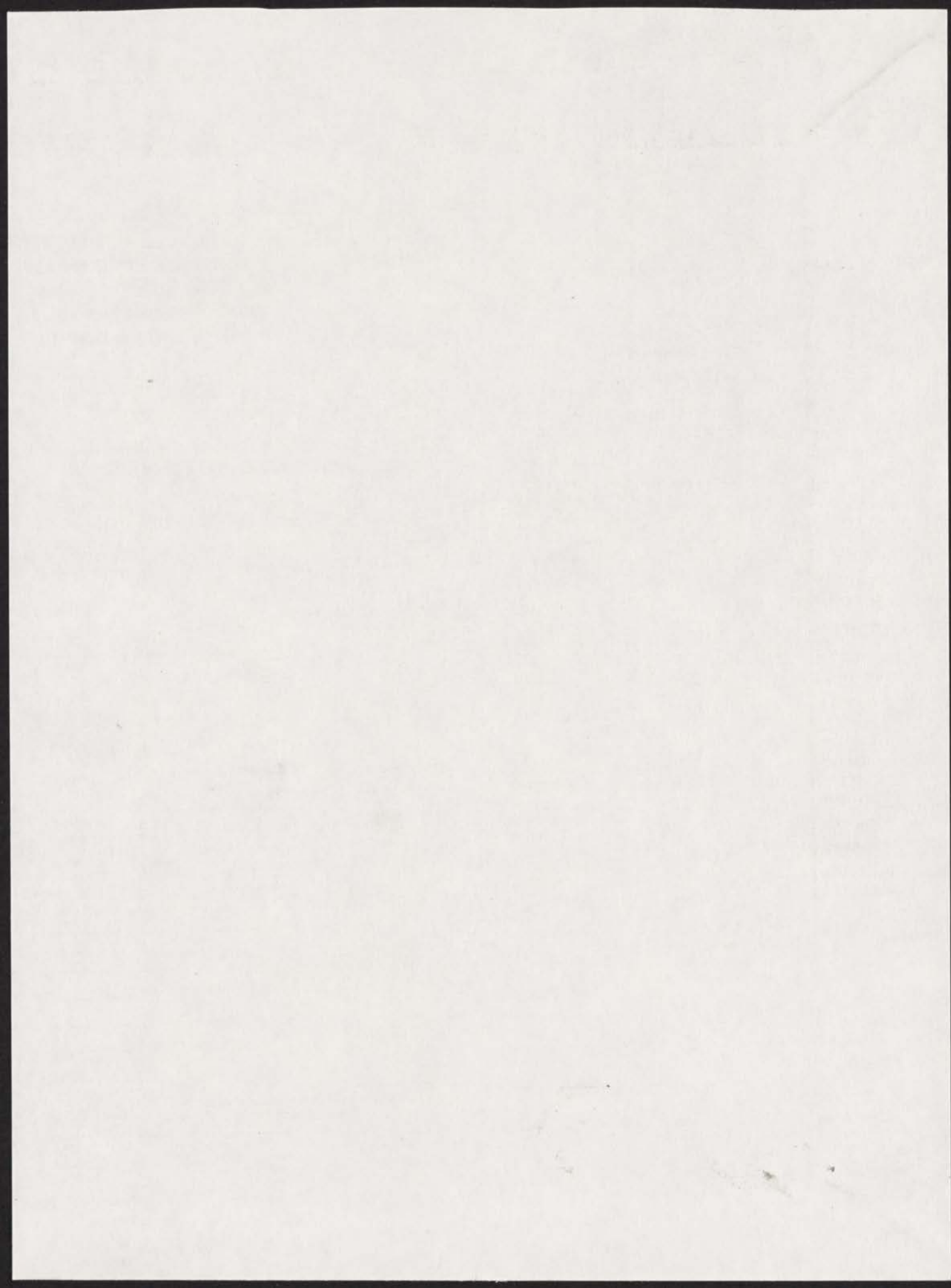
TABLE OF EFFECTIVE DATES AND TIME PERIODS—SEPTEMBER 1992

This table is used by the Office of the Federal Register to compute certain dates, such as effective dates and comment deadlines, which appear in agency documents. In computing these

dates, the day after publication is counted as the first day.
When a date falls on a weekend or holiday, the next Federal business day is used. (See 1 CFR 18.17)

A new table will be published in the first issue of each month.

DATE OF FR PUBLICATION	15 DAYS AFTER PUBLICATION	30 DAYS AFTER PUBLICATION	45 DAYS AFTER PUBLICATION	60 DAYS AFTER PUBLICATION	90 DAYS AFTER PUBLICATION
September 1	September 16	October 1	October 16	November 2	November 30
September 2	September 17	October 2	October 19	November 2	December 1
September 3	September 18	October 5	October 19	November 2	December 2
September 4	September 21	October 5	October 19	November 3	December 3
September 8	September 23	October 8	October 23	November 9	December 7
September 9	September 24	October 9	October 26	November 9	December 8
September 10	September 25	October 13	October 26	November 9	December 9
September 11	September 28	October 13	October 26	November 10	December 10
September 14	September 29	October 14	October 29	November 13	December 14
September 15	September 30	October 15	October 30	November 16	December 14
September 16	October 1	October 16	November 2	November 16	December 15
September 17	October 2	October 19	November 2	November 16	December 16
September 18	October 5	October 19	November 2	November 17	December 17
September 21	October 6	October 21	November 5	November 20	December 21
September 22	October 7	October 22	November 6	November 23	December 21
September 23	October 8	October 23	November 9	November 23	December 22
September 24	October 9	October 26	November 9	November 23	December 23
September 25	October 13	October 26	November 9	November 24	December 24
September 28	October 13	October 28	November 12	November 27	December 28
September 29	October 14	October 29	November 13	November 30	December 28
September 30	October 15	October 30	November 16	November 30	December 29



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